KANSAS
PUBLIC HEALTH NURSING

and

Administrative Resources Guidebook

Kansas Department of Health and Environment
Office of Local & Rural Health
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Forward:

This manual is dedicated to local health department administrators and nursing directors in recognition of their continuing efforts to enhance organizational competence and assure professional performance. It is a gift from the Public Health Nurse Specialist of the Office of Local and Rural Health.

Kansas Department of Health and Environment

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INTRODUCTION

Public Health in America

VISION:
Healthy People in Healthy Communities

MISSION:
Promote Health and Prevent Disease and Injury

Public Health:

- Prevents epidemics and the spread of disease
- Protects against environmental hazards
- Prevents injuries
- Promotes and encourages healthy behaviors
- Responds to disasters and assists communities in recovery
- Assures the quality and accessibility of health services

Essential Public Health Services:

- Monitor health status to identify and solve community health problems
- Diagnose and investigate health problems and health hazards in the community
- Inform, educate, and empower people about health issues
- Mobilize community partnerships and action to identify and solve health problems
- Develop policies and plans that support individual and community health efforts
- Enforce laws and regulations that protect health and ensure safety
- Link people to needed personal health services and assure the provision of health care when otherwise unavailable
- Assure a competent public health and personal health care workforce
- Evaluate effectiveness, accessibility, and quality of personal and population-based health services
- Research for new insights and innovative solutions to health problems

Public health competencies related to the essential services are list in Appendix D of this manual.

Historical Summary of Public Health and Public Health Nursing In Kansas

The earliest times of public health dealt with sanitation to prevent death and disease because there was no knowledge of germs, vaccines or antibiotics. In 1858, Florence Nightingale began education and training of nurses. She stressed nursing the room (environment) as well as the patient. Slowly there was a movement toward scientific and social development of public health.

In the United States generally, recorded public health problems came with the British and others coming to the new world. In the 1700's the colonies passed legislation for isolation of smallpox patients and quarantine for ships.

In 1885 the Kansas State Board of Health and local boards of health were established by the legislature. This was a first for states and territories located this far west. The board was appointed by the Governor and was composed of five physicians, one dentist, one veterinarian, one pharmacist, one hospital administrator, and one sanitary engineer. The first division of the State Health Department was Food, Drug, and Sanitation formed in 1904. Dr. Samuel J. Crumbine was appointed the same year as the first Executive Secretary. He was an innovative and tireless worker, and led in the development of some of the programs that remain today: venereal disease and tuberculosis control, stream pollution abatement, and insect and rodent control. His book Frontier Doctor is fascinating reading and a good source of history for early public health in Kansas. Another excellent reference is Lamps on the Prairie, a history of nursing in Kansas.

In 1912, the US Public Health Service and the US Children's Bureau were established. Kansas, a pioneer in advocating for children, created the Division of Child Hygiene in 1925. This was six years before the Shepard-Towner Act, which provided federal funds to stimulate establishment of state-level divisions and bureaus to protect mothers and children in every state. Dr. Lydia Allen DeVilbiss was appointed to direct the division in Kansas. She and two nurses staffed the "Warren Health Railway Car" that crossed Kansas with health promotion information and activities for mothers, children, and all citizens. Over a period of eight years, the health train visited 255 communities, staffed 95 conferences, and gave 94 lectures in addition to making routine examinations and explanations to visitors. Dr. Crumbine was so pleased with the success of the train that in his 1915 annual report he expressed the opinion that "the public health nurse is the cornerstone of all public health work."

The first school nurse was hired in Dodge City in 1916. By 1919, Kansas had 79 Public Health Nurses and Dr. Crumbine recommended and established a Department of Public Health Nursing under the State Board of Health, Division of Communicable Diseases and asked nurse Estelle Patrick to be its leader. Also in 1919, the first full-time county health officers were appointed in Geary, Marion, and Cherokee counties. From then on, at least one new county was added each year so that by 1981, there were 94 local health departments in Kansas.

Dr. C.E.A. Winslow, a professor at Yale University, was prominent leader in the American public health movement, and in 1920 gave the best known and most widely accepted definition of public health:

> "the science and art of preventing disease, prolonging life and promoting health and efficiency through organized community effort for (a) the sanitation of the environment, (b) the control of communicable infections, (c) the education of the individual in personal hygiene, (d) the organization of medical and nursing services for the early diagnosis and preventive treatment of disease, and (e) the development of the social machinery to insure everyone a standard of living adequate for the maintenance of health, so organizing these benefits as to enable every citizen to realize his birthright of health and longevity."

An early recognized standard definition of public health nursing was offered by nurse educator Ruth B. Freeman who was a member of the executive board of American Public Health Association offered an early-recognized standard definition of public health nursing:

> "a special field of nursing in which technical nursing, interpersonal and organizational skills are applied in appropriate relationship to the skills of other members of health and social professions for the conservation of community health. It includes comprehensive nursing care of individuals, families, and groups and in addition, public health measures addressed to the community as a whole, such as epidemiologic investigations, law enforcement or organization of the community for health action."

In 1922 the State Division of Public Health Nursing in Kansas was formed to supplement, coordinate, and standardize the activities of public health nursing. Helda A. Cron, RN, of Cleveland was the division's first Public Health Nursing Director.

By 1929 there were 130 public health nurses serving agencies in Kansas. This number has increased over the years, due in part to outside financial support such as federal programs providing intermittent funding for expansion of nursing services. The number of counties served and the number of local nurses has increased over the years despite these fluctuations in funding. In 1990 there were local community health services available in 104 counties provided by more that 500 public health nurses. Additionally there were approximately 412 school nurses providing services in local school districts.

Since the Division of Public Health Nursing was formed in 1922, its status has changed several times. In 1953, the first three district nurses were hired to act a consultants to local nursing service (including stimulation the development of local services) and to provide services in counties without local nurses. In 1997, the Director of Local Health Services and six Public Health Nurse Specialists, located in the Office of Local and Rural Health provided primary liaison for local public health agencies and community organizations.

Definition of Public Health
from the 1988 Institute of Medicine Report
The Future of Public Health

"fulfilling society's interest in assuring conditions in which people can be healthy"

This definition directs our attention to the many conditions that influence health and wellness, underscoring the broad scope of public health and legitimizing its interest in social, economic, political, and medical care factors that affect health and illness (Turnock).

Definition of Public Health Nursing
A Statement of APHA Public Health Nursing Section
1996

"Public health nursing is the practice of promoting and protecting the health of populations using knowledge from nursing, social, and public health sciences."

Public health nursing practice is a systematic process by which:

1. The health and health care needs of a population are assessed in order to identify subpopulations, families, and individuals who would benefit from health promotion or who are at risk of illness, injury, disability, or premature death;

2. A plan for intervention is developed with the community to meet identified needs that takes into account available resources, the range of activities that, contribute to health and the prevention of illness, injury, disability, and premature death;

3. The plan is implemented effectively, efficiently, and equitably;

4. Evaluations are conducted to determine the extent to which the interventions have an impact on the health status of individuals and the population;

5. The results of the process are used to influence and direct the current delivery of care, deployment of health resources, and the development of local, regional, state, and national health policy and research to promote health and prevent disease.

This definition of public health nursing practice is an update of a statement published in 1980. It has been developed to describe the roles of public health nursing and to provide a guide for public health nursing practice in the evolving health care system (APHA, 1996). The complete (APHA) definition and role of public health nursing is addressed in this manual "Public Health Nursing Practice."

Levels of Prevention

Primary prevention focuses on preventing disease before it occurs or is diagnosed; it prevents problem from affecting people in the first place.

Examples: immunizations, sanitation worksite safety practices, counseling for families with genetic conditions, community fluoridation of water, labeling of heart healthy foods in grocery stores and restaurants, child restraints in cars, provision of fitness trails, shields on tractor power take-offs, smoking cessation programs, positive parenting classes, and dental sealants.

Secondary prevention focuses on early detection and prompt treatment of an existing problem; it prevents a problem from causing serious or long-term effects to the individual or from affecting others.

Examples: cholesterol screening, STD clinics, water testing, early and periodic screening clinics, required reporting of measles, follow-up on a positive Mantoux, routine Pap smears and self-breast exams, treatment of intraocular pressure, dental fillings, and food, beverage, and lodging inspections.

Tertiary prevention focuses on limiting further negative effects from a problem; it prevents an existing problem and its existing consequences from getting worse.

Examples: home health visits for the chronically ill and disabled, speech therapy for an individual with CVA, reporting or vulnerable adults and maltreated children, referral to support groups, and services for children with handicaps.

Intervention Levels

Individual-based Interventions focus on creating changes such as health status, knowledge, or skills in either individuals or small groups. This is typically seen as direct service to clients or residents.

Examples: one-to-one counseling, home health aide supervisory visits, prenatal classes, home care visits, private will testing, emergency medical response to injury, pregnancy testing, case management, and respite services.

Community-based interventions focus on creating changes in populations. They are directed towards groups within the community or, occasionally, towards all people within the community.

Examples: immunization clinics, media campaigns, lodging inspections, bike paths, worksite health promotion programs, health fairs, and scoliosis screenings in the schools.

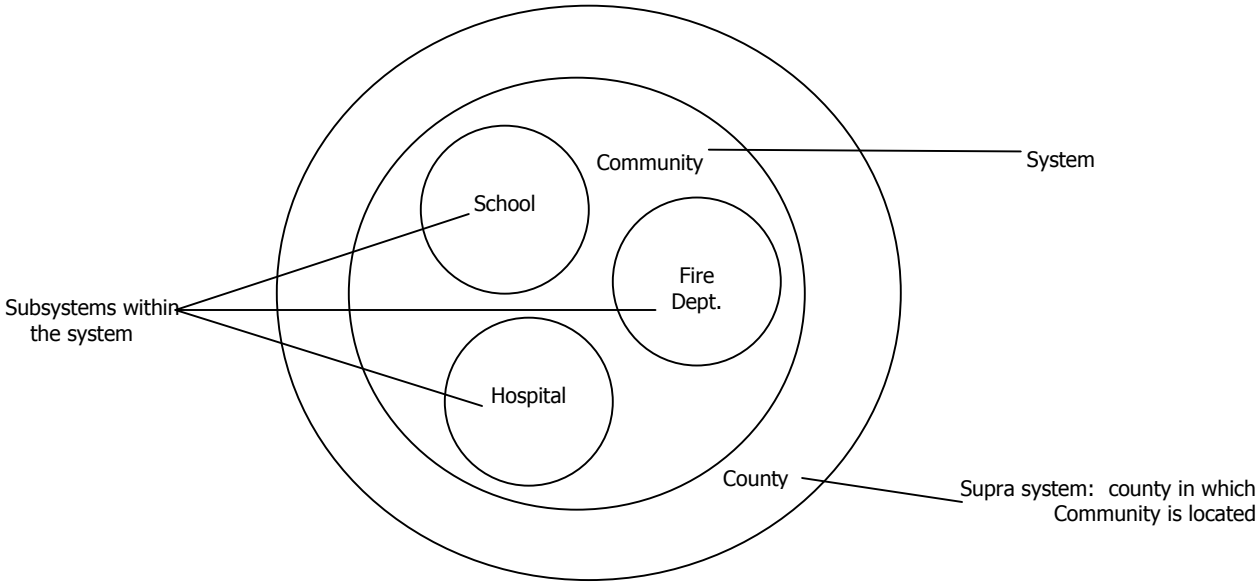
System-based interventions focus on creating change in organizations, policies, laws, and structures. The focus is not directly on individuals or communities but on the system that serves them. Because these systems ultimately impact individuals, changing the system represents a cost-effective and long-lasting way to impact individuals.

Examples: reducing fat in a school lunch program, establishing a smoke-free workplace, reducing the number of grains of baby aspirin per bottle, improving access to health care, improving EMS response time, enforcement of hazardous waste ordinances, and playing an assurance role in home health care.

Systems Theory

Those who oversee the health of the public must be knowledgeable about the health status and health care needs of the community. The Systems Theory identifies many client systems within a community such as the individual, family, groups, organizations, and the community itself. A system is a set of components interacting with each other within a boundary that filters the rate and flow of environmental input and output. A community system may be a specific population living in a geographical area or a group of people with common values, interests, and needs.

Systems are arranged in a hierarchy. Every system has subsystems (components of the system that are also a system), and a supra system. Using the community assessment process as an example, the assessed community is the system, and the subsystems are the people, schools, hospitals, churches, etc. The country is the supra system, the larger system of which the accessed system is a part. The diagram below, (Griffith & Christensen, 1983), illustrated the hierarchical arrangement of a system.

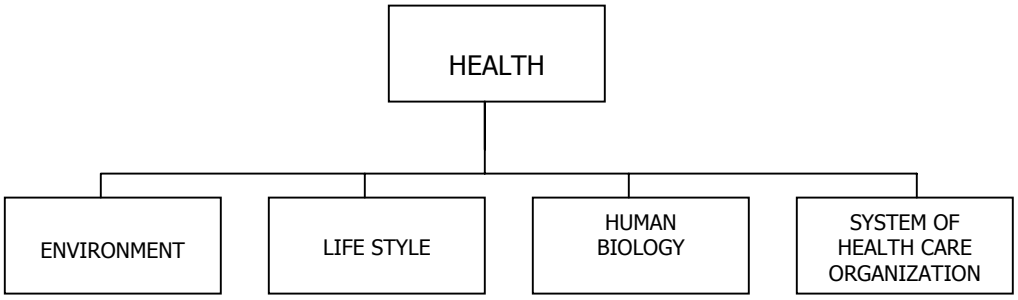


Hierarchical Arrangement of a Community System

All systems are open in that there is a continuous exchange of information with the environment. A healthy system must achieve a balance internally and externally through regulation of the input and output. Through interactions with the environment, the system uses various mechanisms to maintain equilibrium. The systems theory assists the public health nurse and others to identify the community, assess and organize the collected data, set priorities, and plan programs to meet the needs of the assessed system.

Public Health and Epidemiology Models

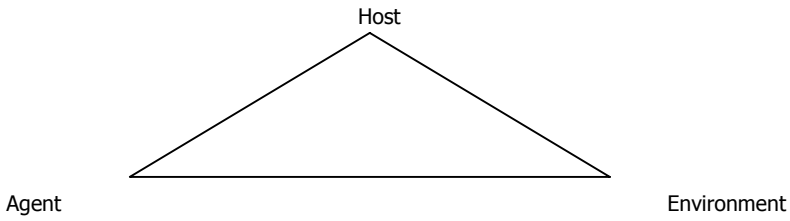
A model well suited for developing preventive measures and health policy is the health field concept with four divisions of factors affecting health. The model was developed in response to the changing disease patterns from infectious to chronic diseases. In the Canadian government document authored by Marc Lalonde, the four divisions are: 1. Lifestyle; 2. Environment; 3. Human biology; and 4. Health care system.



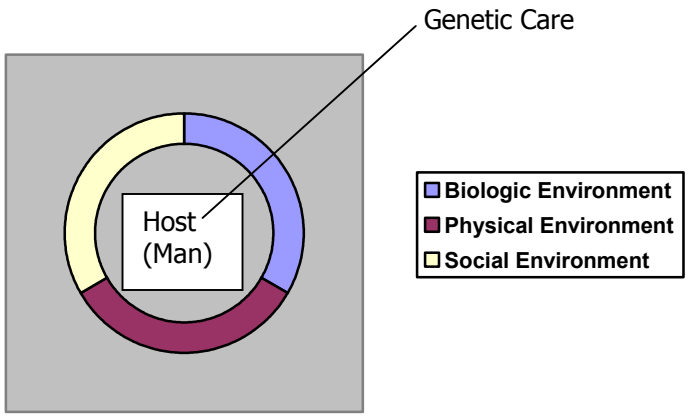
The Health Fields Concept. *Source:* Adapted from *A New Perspective on the Health of Canadians* by M. Lalonde, p. 31. Office of the Canadian Minister of National Health and Welfare. 1974

Lifestyle involves the self-created risks to health from employment/occupational activities, consumption, patterns, and leisure activity. Environment includes social, physical, and psychological aspects. The human biology includes genetic inheritance, complex internal systems, maturation and aging. The health care system includes preventive, curative, and restorative services (Dever, 1991).

The epidemiology triangle is a model used for years showing the three components of host, agent, and environment to predict disease occurrence. This model is a consequence of the acceptance of the "germ theory" postulated by Koch. It assumes a single causative agent and so is considered somewhat outmoded or less important for today's disease patterns. Morris modified this model into a social-ecological model in which the agent is replaced with personal behavioral factors. These are thought to have a greater impact than does the physical environment, but all aspects contribute to a dynamic balance (Dever, 1991).



Another model that fits in well with today's causes of disease is the wheel with the human host containing a genetic core as the center hub surrounded by three sections of biologic, social and physical environments. The model does not emphasize the agent but rather the multiple factors that lead to disease (Orientation to Public Health).



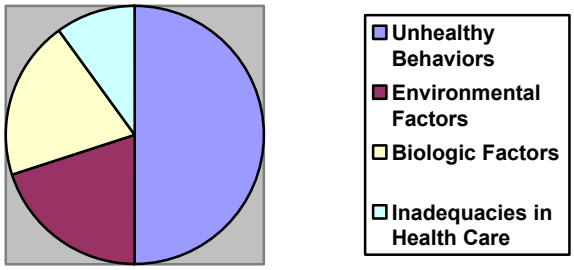
Causes of Death and Disability

It is extremely important for those involved in a community health assessment process to understand basic information regarding causes of death and disability. There are four major factors contributing to premature death:

1. Unhealthy behaviors/Lifestyle
2. Unsafe environmental conditions
3. Inadequacies in the health care system
4. Biologic factors

In the United States, about 50% of deaths before age 75 are caused by unhealthy behaviors, 20% by environmental factors, 20% by biologic factors, and 10% by inadequacies in the health care system (Centers for Disease Control and Prevention, 1994).

Factors contributing to Premature Death



Public Health: CORE Functions
(Institute of Medicine, 1988)

MISSION:

Fulfilling society's interest in assuring conditions in which people can be healthy.

To prevent disease and injury and
To promote, protect and improve
the people's health

CORE GOVERNMENTAL PUBLIC HEALTH FUNCTIONS:

ASSESSMENT – Systematically collect, assemble, analyze and make available information on the community including statistics on health status, community health needs and epidemiologic and other studies of health problems.

POLICY DEVELOPMENT – Development of comprehensive public health policies by promoting use of scientific knowledge in decision-making and by developing public health policy on the basis of a positive appreciation for the democratic political process.

ASSURANCE – Service to achieve agreed upon high-priority goals are provided either by encouraging actions by other entities by requiring such action through regulation or by providing services directly.

Description of Public Health Capacities

Required to Efficiency Perform the CORE Functions Of Public Health

STRUCTURE AND POLICIES – The public health jurisdiction has clear lines of authority, the organizational structure and procedures in place to effectively carry out the core function. (Do we have the necessary authorizations and operational policies to improve performance?)

SKILLS AND RESOURCES – The public health jurisdiction has the workforce and the financing, facilities and equipment required to effectively carry out the core function. (Do we have the personnel, financing and other resources needed to improve performance?)

INFORMATION AND COMMUNICATION – The public health jurisdiction has the capability to receive, process and communicate information, data and reports to effectively carry out the core function. (Do we have access to relevant information and the ability to process and disseminate findings to improve performance?)

COMMUNITY INVOLVEMENT – The public health jurisdiction has processes in place to collaborate with the public it serves, with the officials it represents and with the health providers with which it practices to effectively carry out the core function. (Do we have the ability to influence and integrate performance in the community?)

QUALITY ASSURANCE – The public health jurisdiction has a system in place that incorporates principles of quality management and provides for the routine evaluation of the function to include its relationships with other core functions. (Do we continuously and systematically strive to improve performance?)

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ADMINISTRATION

Strategic Planning

What is Strategic Planning?

Strategic planning is a structural process designed to organize thoughts and plans in a logical manner that people can understand. There are many variations on the theme, many interpretations, but all focus on where an organization or project should progress along a future path. The process is a continuous one, but along the way specific and measurable actions should result.

Why do strategic planning?

It is difficult to move ahead without organizational consensus, and planning is a tool for developing that consensus. The process also encourages thoughtful decision-making about the allocation of scarce resources and helps individuals make decisions about how to structure individual departments, time and expenditure of funds. Strategic planning also sets up measurable parameters that can be evaluated, so that objective progress can be observed.

What are the components of a strategic plan?

Vision

Vision is a grand, global statement. It summarizes the ideal hope of the organization or project. It communicates organizational values. The vision statement is your dream, the way it "ought to be."

Vision example: Healthy Kansas

Mission

Mission is the statement of the special task or purpose of the organization/project. It answers two questions: "What is going to be done?" and "Why is it going to be done?" A mission statement should be outcome-oriented, broad-based, and concise.

Mission example: To increase the physical activity levels of Charles County, Kansas, high school students in an effort to develop a lifelong commitment to exercising on a regular basis, thereby preventing premature death and disability among this population.

Objectives

Objectives spell out in precise terms the goals toward which all activities will be directed. They are the statements of specific and measurable items that relate to the mission and vision. Objectives articulate how much will be accomplished and when the results will be anticipated.

Objectives should answer these questions:
Who? The target of the objective.
What? The action or change to be achieved.
How much? The extent of the condition to be achieved.
When? The time in which change is expected to occur.

Objective example:
By December 1998, increase to 100% the proportion of children in grades 9 through 12 who engage in moderate exercise in school physical education classes at least three days a week. (Baseline: 29%)

Strategies

Strategies are statements that describe how the objectives will be met. They identify approaches that are effective in making changes, such as public awareness campaigns, health education, social marketing, research and evaluation.

Strategy Examples:

Convince the Charles County School Board to enact a policy that requires all students to enroll in a physical education course each year of high school that meets at least three times a week and provides at least 20 minutes of aerobic exercise per session.

Develop a public awareness campaign that educates high school students, their parents, teachers and school board members about the importance of physical activity to health.

Action Plans

Action Plans are detailed working plans for the total strategy. They answer the questions: What? Who? When? Cost? Action plans break down the strategies into individual steps to be accomplished. They should create multiple opportunities for community involvement and leadership development.

Action Plan Examples:

Person Responsible	Cost	Action Step
Journalism Class	$500	By January 1998, develop newsletter articles and posters that highlight the importance of physical education.
Principal	$1,700	By May 1998, enroll all high school PE teachers in a summer college course that provides instruction in the implementation of the "Physical Dimensions" curriculum developed by the Kansas State Board of Education.
Coach Smith	$2,400	By September 1998, initiate additional high school physical education courses that provide aerobic exercise for all students.

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Fiscal Management

Fiscal Management Policies

Accounting records must adequately and accurately reflect the continual changes in assets, liabilities, income, expenses, and equity. It is imperative that the interrelationships among these accounts remain satisfactory.

Financial statements record past business activity and conditions. By careful study and analysis of past performance, the agency will better be able to determine projections for the future. Financial statements must conform to generally accepted accounting principles that are established by the accounting profession. Information contained in the statements is in large part directed to external parties for compliance purposes. Users of the information can determine whether or not the agency has adequately accounted for funds.

Definitions

Assets are the physical, financial, or other values that an agency has. Assets are divided into current and fixed.

Current assets are those that turn over – that is, they change from one form to another – within one year.

Cash includes the currency, the deposits in the checking account in the bank, and other non-interest bearing values that can be converted into cash immediately. It is the most liquid of any of the accounts. Accumulating too much cash means the agency reduces its income-producing capacity.

Accounts receivable form a current asset that results from giving credit to customers when they buy services or goods.

Inventory is an asset that provides a buffer between purchase and sales. Your money is tied up, space is used, products must be maintained and can become obsolete, etc.

Fixed assets are buildings, machinery, fixtures, vehicles, and land. The agency expects to own them for considerable time and writes off part of their cost each period as depreciation expense.

Liabilities are monies borrowed or owed.

Current liabilities are obligations to be paid within one year. They include accounts payable, notes payable, and accrued items (such as payroll).

Accounts payable are usually due within 30-60 days.

Notes payable are written obligations to pay, usually requiring payment of interest.

Long-term liabilities are usually bonds and mortgages.

Equity is the owners' share of an agency after the liabilities are subtracted from the assets.

Revenue is the return from goods and services sold.

Expenses are the costs of performing services. They include materials, wages, insurance, utilities, transportation, depreciation, taxes, supplies, and sales promotions.

Profit is the excess of revenue over expenses.

Loss is the excess of expenses over revenues.

Cost Studies

A COMMON PROBLEM IS THE LACK OF ACCURATE COST INFORMATION, WHICH USUALLY RESULTS IN PROFITS OF UNKNOWN QUANTITY, OR EVEN A LOSS.

Direct costs are costs incurred for a specific purpose that is uniquely traceable to that purpose.

Indirect costs are costs that are associated with more than one activity or product, but are costs that cannot be traced specifically to any one activity or product.

Cost accounting finds that actual costs of a program. The total costs of equipment, facilities (rent, mortgage), personnel (salaries and benefits), and supplies used over a period of time are calculated. The total program costs are divided by the number of clients participating in the program during that time. The total program cost per client is the end product.

Cost benefit studies are a way of assessing the desirability of a program by placing a specific dollar amount on all costs and benefits. If benefits outweigh the costs, then the program is said to have a "net positive impact." Sometimes it is difficult to place values on intangible benefits.

Cost effectiveness is a measure of the quality of a program as it relates to cost. It is a subset of cost benefit analysis and is designed to provide an estimate of costs incurred in achieving a given outcome. This type of study can answer the following questions:

Did the program meet its objectives?
Were clients and staff satisfied with the effects of the interventions?
Are things better as a result of the interventions?

Outcome measures might include increased client knowledge after health teaching, changes in the client's condition after treatment, etc. A cost effectiveness study requires collection of baseline data on clients before the program is implemented and evaluation after the program is completed.

Cost efficiency is the actual cost of performing a number of program services. To determine cost efficiency, productivity must be analyzed.

Productivity is the relationship between what the staff member does and how much it costs him/her to do it.

Cost studies are essential to show the worth of nursing in the marketplace and nurses should be familiar with the results of cost studies so that sound decisions may be made about future program management. Nurses must be ready to identify appropriate program outcomes, client outcomes, and total dimensions of nursing procedures so that appropriate decisions about program management will be made based on adequate information.

Fiscal Records

An agency minimally needs records of the following:

1. **Sales of goods and/or services** – both cash and charge accounts.
2. **Accounts receivable** – amounts of money that other people owe the agency.

3. **Purchases** – inventory purchased from vendors or wholesalers. The first step to keeping track of monies spent on supplies, equipment, etc., is to use number purchase order forms. By ordering everything through purchase order, more control over expenditures will be achieved. There will be increased knowledge regarding the date of ordering, the quantity ordered, the price, etc.
4. **Accounts payable** – money the agency owes to others.
5. **Owners' equity (county tax levy)** – funds invested into the agency by the owner, plus profit, and minus funds removed.
6. **Fixed assets** – to determine proper depreciation and replacement.
7. **Petty cash** – a check is written as needed to cove small itemized expenses and/or to maintain a certain level of cash within the agency.

One purpose of bookkeeping is to provide management and owners with data to be used in decision-making. The main purpose is to provide an accounting of assets, liabilities, expenses, and revenues.

Accounting Systems

The simplest accounting system is one that provides cash control.

Cash basis – can be provided by a good checking account procedure where all receipts are deposited into one account, all payments are made by check, and the bank statement is reconciled each month.

Accrual basis – records income and expenses as of the date they are obligated, whether actual money is transferred or not.

Modified accrual basis – income is recorded when it is received, and expenses are recorded when they are incurred.

ANY ONE OF THE ABOVE METHODS COULD BE USED FOR INCOME AND EXPENSES.

Double-entry accounting involves the process of entering the amount of a transaction twice – as a debit to one account, and as a credit to another.

THERE ARE SEVERAL COPYRIGHTED SYSTEMS PROVIDING SIMPLIFIED RECORDS, USUALLY IN SELF-CONTAINED RECORD BOOKS. A CERTIFIED PUBLIC ACCOUNTANT SHOULD BE CONSULTED BEFORE A SYSTEM IS PURCHASED, TO DETERMINE IF IT WILL MEET THE NEEDS OF THE AGENCY.

Budget

When properly used, budgets should focus attention on planning, improved communication and coordination within the agency. Budgets can provide direction, help to increase awareness of emerging problems, and assist in the development of timely solutions. Additionally, a properly used budget should provide a basis for performance measurement and evaluation.

A well-developed budget should provide a proper basis for control. The budget is a quantification of many subjective judgments and unfortunately is often allowed to become a rather inflexible tool.

Internal Control

The purpose of internal control procedures is to limit errors, promote efficient operations, and protect the agency's assists from fraud, waste, and theft.

The basic principles of good internal control are as follows:

1. Clearly establish each employee's responsibility. For example, if two people have access to the petty cash box and an error is found, it will be difficult to ascertain who is responsible for the error.
2. Maintain adequate records and follow the record keeping procedures in a timely manner.
3. Obtain adequate casualty insurance on assets.
4. Divide duties in the record keeping and maintenance of assets in a particular program or area. For example, one employee should not be placing orders, receiving merchandise, and paying vendors.
5. Rotate employees through job functions, if possible.
6. Obtain employee cooperation by explaining internal control procedures and why they are necessary.
7. Review internal control procedures periodically in order to see that they are being followed, or if necessary, that they are changed.

Fidelity Bond Protection

The system of internal control can make embezzlement difficult, but not impossible. Good control discourages most potential problems, and can often expose fraudulent practices quickly. However, there is still potential for loss of funds through collusion or theft.

Fidelity bond insurance can provide a secondary line of protection. This type of insurance serves as a guarantee, up to a designated amount, against financial loss caused by dishonest acts. The purpose of the bond is to indemnify the agency for loss of money or other property occasioned by dishonest acts of its bonded employees. The bond covers all fraudulent or dishonest acts including larceny, theft, embezzlement, forgery, misappropriation, wrongful abstraction or willful misapplication, committed by employees.

There are various forms of fidelity insurance available to meet the agency's needs. They are:

Individual bond is issued on behalf of the named employee and for a stated amount. This covers only the named employee.

Schedule Bonds are issued if there are several bondable employees within the agency. There are two types of schedule bonds:

Name Schedule Bond covers employees by name, in the respective amounts set for each employee.

Position Schedule Bond provides protection against dishonest acts of employees while they occupy positions listed on the schedule, and in the amount stipulated for each position.

Blanket Bonds are for larger number of bondable employees. There are two types available:

Commercial Blanket Bond covers all employees collectively, and in the event of a loss, regardless whether one or more employee(s) are involved, the aggregate amount collectible is the bond penalty.

Blanket Position Bond also covers all employees, but in the event of a collusive loss, the bond penalty applies to each identifiable employee involved in the loss.

The amount of fidelity bond should be sufficient to protect the firm against disastrous losses, and all appropriate employees should be covered. Agencies frequently bond their personnel not solely because of the reimbursement feature, but because, through their surety companies' records and investigation

services, losses frequently are prevented from occurring. The sureties save the employers time and money by uncovering the history of dishonesty of new employees.

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Local Health Department Revenue and Expenditures

Each year revenue and expenditure information from local health departments is requested for the previous fiscal year. This annual compilation of information provides data reflective of changes in the funding sources and cost centers of local agencies. Data collected is categorized according to sources and must be consistent with findings of independent auditors who conduct annual examination of agency fiscal records.

Revenue

A. Local Tax
   1. County Aid: Includes ad valorem tax, delinquent tax, motor vehicle tax, local sales tax, in-lieu-of tax, possibly other taxes, and any other financial aid from the county.
   2. City Aid: Includes all financial assistance from cities.

B. Fees and Reimburseables
   1. Title XVIII Fees (Medicare): Includes all Medicare receipts.
   2. Title XIX Fees (Medicaid): Includes all Medicaid receipts.
   3. Fees for Service: Includes receipts from every other source including patients and all third party payers.
   4. Other: Includes revenue from sources not included in any other revenue categories.

C. Grants and Contracts

Includes income from all grants and contracts such as those from KDHE, Area Agencies on Aging, other local health departments, etc. Grants and contracts income is separated by origin of funds.

   1. State Grants and Contracts
   2. Federal Grants and Contracts
   3. Other Grants and Contracts

Expenditures

A. Personnel: Includes personal services (salaries).

B. Other Operating Expenditures

C. Capital Outlay.

Sample Fiscal Policies

The following are samples of fiscal policies from which local health department administrators can draw for their agency, as appropriate. They are provided as examples of effective format, and as such, are not intended as an endorsement of policy content or requirement of KDHE.

Budget

The budget is prepared by the Administrator of the department and submitted annually to the County Commissioners for review. The County Commissioners have the responsibility of reviewing and approving the budget of the health department.

It is the policy of the Local Health Department to provide the most appropriate services at the lowest possible cost to meet the needs of its clients, the citizens of _____ County. To do this, the administrator of the department shall review the costs of services provided annually through cost studies including, but not limited to, cost efficiency, cost benefit, and cost effectiveness.

Fees

Fees for services will be reviewed annually by the Administrator and revised according to cost of service and supplies used. Fee schedules will receive final approval form the County Commission.

Some services are covered by various types of insurance, such as, Medicare, Medicaid, Blue Cross/Blue Shield, etc. The Health Department will bill Medicaid for covered services, if the client supplies information regarding the policy they have.

Contracts with Medicare and Medicaid will be kept on file in the agency and updated as indicated by those agencies, in order for the department to receive direct payments.

Other insurance agencies may be contracted with if it is in the best interest of the health department to do so. Contracts with these insurances should be made with consultation from the County Attorney and County Commission by the Administrator.

If the service is not covered by insurance, the client is charged the fees at the time the service is rendered. No one is refused service due to inability to pay. However, clients are encouraged to pay what they can, when they can. Ledger cards are maintained to show each client's account and payments can be made at a later date. The accounts are carried until the end of the fiscal year and then written off the books.

For some services provided by the local health department, there is a sliding scale fee based on available household income. There are a few programs where the client must fill out the income verification as a requirement of the program. The full fee will be charged, unless household income forms have been filled out which indicate payment at a reduced rate.

All monies received from fees, donations, or grants are to be recorded in the cash ledger. A receipt must be made for each entry into the ledger. All clients will be offered a copy of their receipt. All checks are stamped immediately as payable to the _____ County Health Department. If checks are returned for insufficient funds, clients are contacted and requested to make payment in cash. The check is returned to the client upon payment of the fee. The health department will not charge a service fee. If clients are unable to make restitution at that time, the amount owed will be entered on their ledger card and carried to the end of the fiscal year. If the fee has not been paid by the end of the fiscal year, the amount will be written off as uncollected.

At any clinic off site from the department where cash is taken from the cash drawer, a voucher must be made out and signed. When fees are collected at the field site, receipts are made out and the amount of cash returned to the department must be reconciled at the end of the day.

A daily cash deposit is made for the health department either to the department's checking account, or to the County Treasurer's office. A receipt is obtained at that time that must be reconciled monthly in the health department's records.

Three different people are responsible for handling cash processes, so that no one person is responsible for all aspects of handling money.

1. One person opens the mail and lists checks received.
2. One person takes cash fees and makes and enters payments in the appropriate ledgers.
3. One person makes the daily deposit slip for the department that must be reconciled with the cash drawer and the actual cash in hand.

A petty cash fund is maintained in the health department for making change, and for purchases of less than $ _____, as approved by the Administrator. This fund will be reconciled daily.

Payment of Debts

Payment of debts will be done on the 1st working day of the month using the system established by the County.

All bills will be reviewed for accuracy before payment.

All bills will be submitted to the Administrator for approval and signature, prior to payment.

Copies of all bills will be made and kept at the health department for verification and auditing purposes.

Payment of all bills will be issued from the County Clerk's office, unless otherwise requested by the Administrator.

Payroll

Hours worked will be submitted to the Administrator for approval on the __th (date). Sick leave, vacation, or absences will be recorded.

Time records will then be turned in to the County Clerk's office.

Payroll checks will be issued (at the time designated in the County Policies).

Gross and net amounts of each payroll check will be recorded and kept by (the County Clerk), and will be available to the Administrator for grant writing and budgeting purposes.

Record Keeping

There are several copyright systems providing simplified records, usually in self-contained record books or software. The policies of the health department should follow the system they utilize. If no system has been purchased or utilized, consult a certified public accountant.

Auditing

All financial records will be subject to an annual audit pursuant to KSA 75-1122, by a certified public accountant or a licensed municipal public accountant designated by the County.

Indirect Cost Reports

If a local agency wishes to claim indirect costs as matching funds, it must submit an annual indirect cost proposal (Universal Contract, #17). Proposals are submitted to Internal Management, KDHE, for approval to use in budget allocations for state health agency grants.

> Direct Costs are those that can be identified specifically with a particular program. Typical direct costs chargeable to grant programs are salaries, materials, supplies, equipment, and other items of expense incurred specifically to carry out program objectives.
>
> Indirect Costs are those (a) incurred for a common or joint purpose benefiting more than one program or cost objective and (b) not readily assignable to the programs or cost objectives specifically benefited without effort disproportionate to the results achieved.

Some costs are not allowable such a bad debts, depreciation, and some capital expenditures. It is necessary to perform periodic time studies of professional staff and clerical staff to determine salary allocations per program. When preparing budgets, multiply the direct costs of each program by the percent of approved indirect costs and these dollars can then be shown as match.

For guidance in developing an indirect cost proposal, obtain a copy of OMB Circular A-87, Cost Principles for State, Local, and Indian Tribal Governments, from the Document Distribution Center, Office of Administration, G-236 New Executive Office Building, Washington, D.C. 20402.

For further guidance, you may wish to consult with the CPA firm that conducts your county audit. If you have further questions. Please call Internal Management at 785-296-1524.

COMPUTING INDIRECT RATE

$$\text{Divide } \frac{\text{Indirect costs}}{\text{Total Direct Costs}} = \%\text{ of Indirect Costs}$$

Send you Agency's INDIRECT COST PROPOSAL for approval to:

Internal Management
Kansas Department of Health and Environment
Curtis Building
1000 SW Jackson, Suite 570
Topeka, KS 66612-1368

Aid to Local Units Grant Application and Award Process

Time Frames

The following schedule establishes Time frames for the application and award proves:

September 15 – Grant application guidelines and reporting requirement packets are reviewed and revised by program staff to assure accurate program objectives and funding criteria for current year.

December 15 – The Grant Application and Reporting Guidelines are approved. Final preparation of packet includes personnel allocation by program and budget forms required for submission.

January 15 – Grant application packets are mailed to local units and other interested applicants.

March 15 – Grant applications postmarked no later that March 16 are returned to the state health agency for consideration for funding.

During the period March 16 to April 15, KDHE staff work with local agency staff to clarify issues related to programs or the applications, review contract program attachments and recommend final awards.

April 20 – Meeting of KDHE Grant Review Committee, which includes the Director of the Division, OGS, Bureau Directors and Program staff to present funding plan. Recommendations are reviewed, substantive problems identified and resolutions determined prior to a final funding decision and approval by the Division Director.

May 1 – Final funding decisions and approved contract program attachments are provided to Internal Management for preparation of contracts.

May 15 – Contracts are mailed to Awardee from Internal Management.

Note: References to local health departments are intended to include all agencies applying for grant funding assistance. If specified dates fall on a weekend or holiday, then the first following workday is applicable.

Monthly/quarterly affidavits of expenditure and required progress reports are submitted as a single packet to Internal Management.

Grant Application Information

Each year, the Kansas Department of Health and Environment makes federal and state funds available to local units of government and other eligible agencies to support public health services in local communities. The goal is to support services, which maintain and improve the health of Kansas's citizens. There are two types of funding to local agencies:

1. State Formula Funds – General Health Services

   These funds are available to county health departments on a formula basis to support general health services. To be eligible for these funds, the agency must be a county, city-county or multi-county health department supported by sufficient local tax revenues and expenditures to meet the maintenance of effort requirements.

2. Categorical Grant Funds

   These funds support more specific or targeted health service needs. Continued funding is not automatic. Each year, a completed application for each type of funding must be submitted to KDHE by the established deadline. The applicant must meet local matching requirements for each type of categorical funds requested.

Successful administration of grant funds requires that the local agency:

1. Comply with federal and state policies and regulations.

2. Bill Medicaid or other third party payers for services provided to eligible clients. The project must develop and implement a cost-based sliding fee scale. Funds generated from client fees or third party reimbursement must be used to support the maintenance and/or expansion of services.

3. Implement an annual staff education plan that: (a) identifies education needs of existing staff and plans for upgrading provider skills in identified needs areas; (b) includes a provision of attendance at annual KDHE update in primary service area; and (c) provides for orientation and in-service of new staff.

4. Provide integrated services and client records and implement multi-program staff meetings.

5. Provide each member county of multi-county projects with a copy of the grant application guidelines, completed application package, related program contracts, KDHE Local Agency Grant Reporting Instructions, and have on file a signed memorandum of agreement with each participating county.

6. Submit documentation of (a) progress in achieving objectives, and (b) expenditures. Documentation is used to understand public health needs and services in the state, and convey information and data to relevant federal and state agencies.

   Fiscal control and fund accounting procedures must exist to assure the proper disbursement and accounting of grant funds. Cost center accounting should be established to document revenues and expenditures for each type of funding. The accounting system should reflect all receipts, obligations, revenue, and disbursement of grant and local funds.

   The local agency is fully responsible for providing individual employee coverage for workers compensation, unemployment insurance, and social security. The agency is also responsible for

income tax deductions, other tax or payroll deductions, and providing any benefits required by law for those employees who are employed on behalf of the grant program.

Information required for grant funding of local health services, including instructions and forms for completing application, are available from:

Office of Local and Rural Health
1000 SW Jackson, Suite 340
Topeka, KS 66612-1365

Contracts and Agreements

Contract with local agencies contain four principle parts:

The **Universal Contract** contains broad agreements between KDHE and the local agency. It defines the parameters of the relationship, responsibilities, and the requirements of the law. The Universal Contract is signed only once by each party and become a part of the permanent records of the local agency. It remains in effect until terminated by either party or updated by review and is automatically renewed by the local agency when the first warrant of the new grant year is cashed.

The **Contract Attachment** is provision specific to each individual program. The Attachment defines the goals of the program, anticipated outcomes, and legal requirements for participation. It is signed by both parties one time only, remains in effect until terminated by either party or updated by review, and is renewed by cashing the first warrant of the new grant year. The Attachment becomes part of the permanent records.

The **Notice of Grant Award and Program Objectives Summary** is issued at the beginning of the grant period and when amendments occur. It includes the specific terms of agreement for each program for the current fiscal year and clearly defines the expectations, performances objectives, cash award and budget. It does not require a signature because it is included by reference in the Contract Attachment. Cashing the first warrant signifies acceptance of the grant amount and the program objectives.

The **List of Grant Awards** is issued at the beginning of each grant period and when amendments occur. It summarizes all the grants awarded to an agency and does not require signatures. The list includes the sources of funding for each program to facilitate audit procedures.

Grant Reporting Information

Reports required for contracts/grants awarded to local agencies are defined in the KDHE document, "Grant Reporting Instructions "and are revised yearly in order to meet individual program requirements. There are two elements, the quarterly or semi-annual program progress report and the fiscal report, which are submitted at the same time. Program and fiscal staff make a joint review of the materials. Future payments to grantees are withheld until the total report is received and approved.

Quarterly **Certified Expenditure Affidavit Reports** are due at the Kansas Department of Health and Environment by the 15th of the month following the quarter, e.g., July-September, due October 15th. No annual reports are required. Program reports should be submitted as specified within each Grant Award.

Two (2) copies (Original plus one copy) of program and fiscal reports are to be mailed to:

Internal Management
Kansas Department of Health and Environment
1000 SW Jackson, Suite 570
Topeka, KS 66612-1368

Complete information can be obtained by requesting, "Grant Reporting Instructions", from:

Office of Local and Real Health
1000 SW Jackson, Suite 340
Topeka, KS 66612-1365

Local Maintenance of Effort

H.B. 2018, section 1 (c) as enacted by the 1991 Legislature amended K.S.A. 65-242 as follows:

> "If local tax revenues allotted to a local health department for a fiscal year fall below the level of local tax revenues allotted to the local health department for the preceding fiscal year, the amount of state financial assistance under this act for which such local health department is eligible for the fiscal year shall be reduced a dollar amount equal to the dollar amount of reduction in local tax revenue for that fiscal year."

H.B. 2018 changed the base period for computing the Maintenance of Effort requirement. (Previously, the base period for comparing the contribution from local tax revenues had been the year"… when state grant funding was last increased.") Effective with the county fiscal year beginning January 1, 1992, and each year thereafter, the base period will be the "preceding fiscal year" regardless of whether that was the year of the last increase. Calendar years will be used for comparing local contribution levels in relation to general health grants. Comparison of the new local tax revenues for the present calendar year with the amount of new local tax revenues necessary for the coming calendar year, permits county governments to know the minimum new local revenue necessary. If local tax revenues are decreased, the amount of the state grant will be decreased a like amount.

A carryover balance that remains in the health fund cannot be transferred out of the health department's health fund to be used for other than health-related purposes (K.S.A. 79-2934, a part of the municipal budget law). However, transfers to a "health capital outlay" fund would be considered a health-related purpose. Also, a carryover balance that remains in the health fund does not count towards meeting the next year's requirement for availability of new local tax revenues.

In summary:

- To participate in the General Health Grant program to the fullest extent possible (i.e. collect maximum funds possible), the new local tax revenues available for a calendar year must be equal to or greater than local tax revenues available for the previous calendar year. Levels of state fiscal year funding for each participating local health department are determined by formula and are part of the Grant Application Guidelines distributed to local agencies every year.

- Local health-related tax revenues cannot be transferred for other purposes.

- Year-end balances in health related funds cannot be carried forward and counted when determining the amount of NEW local health-related tax revenues available for compliance with K.S.A. 65-242.

Certification of Local Maintenance of Effort

To facilitate a comparison of local revenues, local health departments certify, to Internal Management, KDHE, the amount of tax revenues included in their budgets for the preceding year and that, which is budgeted for the coming year. The forms are completed and returned to Internal Management no later than November 5.

TO: KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT
INTERNAL MANAGEMENT
1000 SW JACKSON, SUITE 570
TOPEKA, KS 66612-1368

SUBJECT:CERTIFICATION OF LOCAL MAINTENANCE OF EFFORT

I. Amount of Local Tax Revenues included in Calendar Year ___
Health Budget. _____

II. Amount of Local Tax Revenues Included in Calendar Year ___
Health Budget. _____

I certify that the above information true and correct and represents the amounts contained in the official Health Department budgets for Calendar Years _____ and _____.

_____
Local Health Official

Date: _____

Fee for Service/Sliding Fee Scale

Fee for service is established by local policy in compliance with state and federal guidelines (i.e. Title X guidelines). Public health principles, however, dictate that some services not be withheld because of inability of the individual to pay, when the protection of the health of a population is at risk. An example of this is STD treatment. Additionally, local health departments may not charge for state or federally provided materials, but may in some instances charge an administration fee.

Use of a sliding fee scale is required for many federally funded programs, particularly maternal and child health programs and WIC. This scale is based on Poverty Guidelines updated annually by the U.S. Department of Health and Human Services and published each year in the Federal Register. These poverty guidelines are a simplified version of the Federal Government's statistical poverty thresholds used by the Bureau of the Census to prepare its statistical estimates of the number of persons and families in poverty. Definitions of "income," "family," "family unit," or "household" are not universal and usually are outlined by the program requiring use of the guidelines.

Human Resources Management
(Personnel)

A Guide to Interviewing

Introduction

These guidelines have been prepared by the State of Kansas Department of Administration Division of Personnel Services to help interviewers conduct fair and objective interviews. An interview should provide as much information as possible about an applicant's potential to perform the duties of a particular position. The most valuable interview is objective and permits the interviewer(s) to determine the knowledge, skills, and abilities of a prospective employee.

Interview Development

Form the Interview Team - If feasible, use a team approach. The team approach is preferable because it saves time and allows for comparison of the applicants by the team members. The size of the interview team may vary, but generally two or three members are recommended.

Familiarize the Interviewer(s) with the Position - The interviewer(s) must be familiar with the major duties and responsibilities, and the essential knowledge, skills, and abilities of the position at entry level. Be sure that each interviewer reviews the position description carefully.

Establish Criteria for Selection - The selection criteria must be consistent with the complexity and level of the job. Focus on performance factors that can be demonstrated in the selection procedure. Understand the departmental and organizational goals as they relate to this position. Such criteria must be job-related and might include performance during the interview, relevant training, education and experience, affirmative action goals, etc. Example: to what extent is job success dependent upon effective oral communication skills, on-the-spot reasoning skills, and the ability to effectively present oneself to strangers?

Develop Job-related Questions - "Nice to know" questions are not permitted! Lawsuits may result from applicants who are rejected on the basis of irrelevant questions asked by interviewers.

Develop Interviewing Strategies - There are many different interviewing strategies. Develop strategies that are appropriate for the position level and skill requirements.

Establish a System to Evaluate the Responses - It might be beneficial to set up a formula for rating or ranking the applicant's responses to the questions based on the selection criteria. Evaluating the responses in this manner will help make the selection process easier and more objective.

Interview Suggestions

Preparing Questions

When developing questions, always keep in mind that they must be job-related and appropriate for the complexity and level of the position. It is helpful to weigh the questions based on the importance of each selection criterion. Below are six main categories of questions that are commonly used by interviewers. Different types of questions may be combined to obtain a certain response.

1. Close-ended questions. These questions may sometimes be helpful when an interviewer(s) wants to know certain information at the outset or needs to determine specific kinds of knowledge. Example: "Could you name the five specific applications involved in…?

2. Probing questions. These questions allow the interviewer(s) to delve deeper for needed information. Example: "Why?", "What caused that to happen?", or "Under what circumstances did that occur?"

3. Hypothetical questions. Hypothetical situations based on specific job-related facts are presented to the applicant for solutions. Example: "What would you do if.."; "How would you handle…"

4. Loaded questions. These questions force an applicant to choose between two undesirable alternatives. The most effective way to employ a loaded question is to recall a real-life situation where two divergent approaches were both carefully considered, the frame the situation as a question starting with, "What would be your approach to a situation where…"

5. Leading questions. The interviewer(s) sets up the question so that the applicant provides the desired response. When leading questions are asked, the interviewer cannot hope to learn anything about the applicant.

6. Open-ended questions. These are the most effective questions, yield the greatest amount of information, and allow the applicant latitude I responding. Example: "What did you like about your last job?"

Determining Strategies

Although there are many different interviewing strategies, the following are three different perceptive strategies.

1. Situational interviewing. This strategy is based on the assumption that the closer you can get to a real work situation, the better the evaluation will be. The situational interview could involve taking a tour of the workplace and asking the interviewee to actually perform some aspect or a closely related aspect of the job.

2. Stress interviewing. This strategy calls for the use of tough or negatively phrased questions. The interviewer(s) is trying to keep the candidate off balance while evaluation poise and quick thinking under pressure. Their style would <u>not</u> be suitable if the employee will not face undue stress on the job.

3. Behavioral interviewing. The interviewer(s) is looking for a behavioral pattern. All questions are based on the past. The assumption is that a "Leopard never changes its spots." The interviewer(s) may get an idea of what action the interviewee might take in the future based on what happened in the past.

Each of these strategies has its strengths and weaknesses. One strategy should not be used exclusively for all interviews. Different position levels might require different interview approaches. The sensible approach is to take the best aspects of each style and combine them to produce a comprehensive strategy.

Evaluating Responses

As part of evaluating the responses, the interviewer(s) should review the job description to ensure thorough familiarity with the requirements, duties, and responsibilities of the position. Furthermore, the interviewer(s) should review the work history and relevant educational credentials of each candidate and consider the intangible requirements of the job. Finally the interviewer(s) should review the selection criteria, evaluate and rate the responses, and rate the applicants based on those criteria.

Interview Process

Pre-Interview

1. Schedule interviews to allow sufficient time for post-interview discussion, completion of notes, etc.
2. Secure an interview setting that is free from interruptions and distractions.
3. Review applications and resumes provided by the applicant.
4. Provide an accurate position description to each applicant and allow adequate time for reading before the interview begins.

Opening the Interview

1. Review the functions of the agency or unit in which the position is located.
2. Allow the applicant an opportunity to pose questions or seek clarification concerning the position.
3. Explain the interview process to the applicant.

Questioning

1. Question the applicant following the method established in the developing stage.
2. Be consistent with all applicants.
3. Allow the applicant sufficient time to respond to each question.
4. Record any relevant information elicited from the questions.

Closing the Interview

1. Inform the applicant when the decision will be make and how notification will occur.
2. Confirm the date of the applicant's availability to begin work.
3. Confirm the applicant's correct address and telephone number.
4. Give the applicant a final opportunity to raise any questions.
5. Obtain all necessary information from the applicant about references.

Post Interview

1. Review the selection criteria.
2. Review and complete notes.
3. Avoid prejudgment and discussion of applicants between interviews.
4. Use the selection criteria established in the developing stages.
5. Rank the applicants based on the selection criteria.
6. When possible, decide upon a second and third choice in the event the first choice should decline the offer.
7. Document the basis for the final recommendation.
8. Notify all applicants interviewed of the results prior to announcing the selection.

Guidelines for Employment Inquires

The following chart is to be used as a guide to formulate questions, which will elicit the information needed to make employment decisions.

Permissible Inquiries	Inquiries which must be avoided
Name Questions, which will enable work and education records to be checked.	**Name** Inquiry about the name, which would indicate lineage, ancestry, national origin, descent, or marital status.
Age If age is a legal requirement, whether applicant meets the minimum or maximum age requirements; upon hire proof of age can be required.	**Age** If age is not a legal requirement, any inquiry or requirement that proof of age be submitted must be avoided. NOTE – the Age Discrimination in Employment Act, as amended in 1986, prohibits discrimination against people over 40. The Kansas Act Against Discrimination prohibits discrimination against people age 18 and over.
Race or Color Race may be requested for affirmative action statistical recording purposes. Applicants must be informed that the provision of such information is voluntary.	**Race or Color** Any inquiries, which would indicate race or color.
Gender Inquiry or restriction of employment is permissible only where a bona fide occupational qualification exists. (This BFOQ exception is interpreted very narrowly by the courts and EEOC.) The employer must prove that the BFOQ exists and that all members of the affected class are incapable of performing the job.	**Gender** Any inquiry, which would indicate gender.
Marital and Family Status Whether applicant can meet specified work schedules and/or will be able to travel.	**Marital and Family Status** Any inquiry, which would reveal marital status, information on applicant's children, child-care arrangements, or pregnancy.

Disabilities	**Disabilities**
Under the provisions of the Kansas Act Against Discrimination, as amended, and the Americans with Disabilities Act of 1990, applicants may be asked if they are able to perform the essential duties of the position with or without reasonable accommodation.	Whether an applicant is disabled or inquiry about the nature of severity of the disability. Note – Except in cases where undue hardship can be proven, employers must make reasonable accommodations for an employee's disability. Reasonable accommodation may include make facilities accessible, job restructuring, modified work schedules, modifying examinations, training material or policies, acquiring or modifying equipment or devices, or providing qualified readers or interpreters.
Religion	**Religion**
Employers may inform applicants of normal hours and days of work required by the job. NOTE – except in cases where undue hardship can be proven, employers must make reasonable accommodations for an employee's religious practices. Reasonable accommodation may include voluntary substitutions, flexible scheduling, lateral transfer, change of job duties, or use of annual or vacation leave.	Any inquiry, which would indicate applicant's religious practices and customs.
Address	**Address**
Address may be requested so that the applicant can be contacted. Names of persons with whom applicant resides may be requested for compliance with the nepotism policy.	Any inquiry, which may indicate ethnicity or national origin.
Ancestry or National Origin	**Ancestry of National Origin**
Languages applicant read, speaks or writes and the degree of fluency if a specific language is necessary to perform the job.	Inquiries into applicant's lineage, ancestry, national origin, descent, birthplace, or native language; how applicant learned a foreign language.

Arrest, Conviction, and Court Records	**Arrest, Conviction, and Court Records**
Inquiry into arrest records and actual convictions, which relate reasonably to fitness to perform a particular job. ARREST – The employer must consider whether the alleged conduct is job-related, the likelihood that the alleged conduct was actually committed, and the time that has passed since the arrest. CONVICTION – the employer must consider the nature and gravity of the offense(s), the time that passed since the conviction and/or completion of the sentence, and whether the conduct for which the applicant was convicted is job-related.	Ask or check into a person's arrest, court, or conviction record if not substantially related to functions and responsibilities of the particular job in question.
Birthplace and Citizenship	**Birthplace and Citizenship**
If United States citizenship is a legal requirement, inquiry about the citizenship of an applicant is permissible. The Employment Eligibility Verification (Form I-9) must be submitted by those who are hired to provide evidence of identity and employment eligibility.	Any inquiry, which would indicate the birthplace of the applicant or any of the applicant's relatives.
Military Service	**Military Service**
Type of education and experience gained as it related to a particular job.	Type of discharge.
Photograph	**Photograph**
Statement that a photo may be required after hire for purposes of identification.	Any requirement or suggestion that a photo be supplied before hiring.
Education	**Education**
Applicant's academic, vocational or professional education; schools attended.	Any inquiry that would indicate the nationality, racial, or religious affiliation of a school; years of attendance and dates of graduation.
Experience	**Experience**
Applicant's work experience, including names and addresses of pervious employers, dates of employment, reasons for leaving, and salary history.	Any inquiry regarding non-job-related work experience.

Financial Status If required for business necessity, questions concerning financial stability. Examples of agencies that make inquiries into applicants' financial status are the Kansas Highway Patrol Kansas Bureau of Investigation, and the Kansas Lottery.	**Financial Status** If not required for business necessity, questions concerning financial stability.
Notice in Case of Emergency Name and address of person(s) to be notified in case of accident or emergency may be requested after selection is made.	**Notice in Case of Emergency** Name and address of relative(s) to be notified in case of accident or emergency.
Organizations Inquiry into the organizations to which an applicant belongs and offices held relative to the applicant's ability to perform the job sought.	**Organizations** A list of all organizations to which the applicant belongs.
References Names and addresses of persons who will provide professional and/or character references for applicant.	**References** Requirement that a particular individual supply a reference.
Relatives Names of applicant's relatives already employed by the state agency in which employment is sought for compliance with the nepotism policy.	**Relatives** Name or address of applicant's relatives who are not employed by the same agency in which employment is sought. NOTE – Any inquiry should be avoided which, although not specifically listed among the above, is designed to elicit information which is not needed to consider an applicant for employment. REFERENCE: State of Kansas Department of Administration Division of Personnel Services, form D.A. 286, (Rev. 3/92).

Sample Interview Questions

Administrative/Supervisory Positions

1. Describe your education and experience, which has prepared you for this position.
2. Describe your management style.
3. How would you conduct planning and goal setting for the agency?
4. How would you assure that goals and objectives are attained?
5. How would you manage conflict between staff members?
6. What do you see for the future of public health? For the agency?
7. This position requires some overnight travel. Is that workable for you?
8. What questions do you have regarding this positions?

Public Health Nurse Positions

1. Describe your education and experience, which has prepared you for public health nursing.
2. Why do you want to be a public health nurse?
3. Describe the skills in which you are strongest.
4. What skills would you need to learn or update for this position?
5. What type of work environment enables you to perform best?
6. In this position, you will deal with people from a variety of different cultures and lifestyles. What experiences have prepared you for this?
7. How do you manage conflict with co-workers?
8. This position requires some overnight travel. Is that workable for you?
9. What questions do you have regarding this position?

Model Orientation Program

A. Purpose: To provide a process of orientation about community health to new employees and to promoter the competent performance of their duties.

B. Objectives:
   1. Define the specific job to be performed and determine the information and skills needed.
   2. Establish the employee's baseline of knowledge and skills.
   3. Provide a mechanism for the employee to develop knowledge and skills necessary for job performance.
   4. Provide the new employee with the concepts and principles of community health nursing.
   5. Provide the new employee with an understanding of the department's total program.

C. General guidelines: Orientation is an ongoing process that takes place over a period of time. A beneficial way to approach the orientation process is to divide it into two phases: the orientation phase and the training phase. The orientation phase primarily covers the items that deal with personnel policies, workgroup, and general orientation to the agency. The training phase is longer and deals with assisting the employee to develop the knowledge and skills necessary to fulfill the position description. A suggested time framework is presented to assist the supervisor in developing a planned orientation.

D. Time Frame suggestion:
   1. Day 1 Goals: It is advisable for the supervisor to prepare for the arrival of the new employee in order to have an effective, organized orientation. Information that is presented should be introduced throughout the day, allowing time for questions and integration of the data. The successful first day will provide the employee with a felling of accomplishment as well as acceptance into the workgroup.
      a. Integrating the new employee into the workgroup:
         - Prepare the employee's work ahead of time with supplies needed to do the job.
         - Plan introductions over the entire day to avoid overwhelming the new employee. Nametags are helpful.
         - Provide the new employee with a list of names of people she or he will be meeting to assist with retention of names.
         - Explain how the new employee's work will relate to the work of others.
         - Designate a co-worker to take the new employee around during breaks, lunch, or to help if the supervisor is absent.
         - Have a "welcome aboard" lunch.
         - As a supervisor, make yourself available for questions and requests.
         - Don't hand the employee a pile of things to read (i.e., personnel policies, reports, etc) and leave him or her on his or her own.
      b. Day 1 activities might include:
         - Discussion of personnel policies, work hours, breaks, lunch, overtime, payday, vacation, sick leave, etc.
         - Line of organizational authority.
         - Organizational structure.
         - Review position description.
         - Review confidentiality policy
         - Location of supplies and equipment.
         - Proper attire.
         - Location restrooms, lunch facilities, coffee, parking, etc.
         - Procedure for reporting illness/tardiness.
         - Orientation to phone system
         - Introduction to workgroup
         - Introduction to the secretary who will perform duties for the new employee

- Probationary period requirements.
- Completion of personnel and tax forms.
- Plan an activity that deals with the employee's major program area (example: preview files to familiarize with forms and trends; review a report recently completed; inventory program-related public information materials to become familiar with available publications; observe a program-related clinic; accompany a co-worker on program-related home visit; or research a point of needed information related to the program area.

2. Week 1 Goals: Activities should be scheduled to build on the knowledge foundation laid on Day 1. Plan work, which will produce a feeling of self-worth. The supervisor should begin to provide feedback on performance. This feedback should be informative rather than evaluative, descriptive rather that judgmental, and factual rather that vague.
   a. Activities to be accomplished by the end of week 1 might include:
      - Procedure for travel expense reimbursement
      - Performance evaluation criteria.
      - Introduction to all department program area.
      - Record keeping and documentation.
      - Accident prevention and reporting procedures.
      - Emergency procedure.
      - Fire drill and Disaster procedure.
      - Care of equipment.
      - Orientation to structure of community.
      - Discuss the role and function of public health and the public health nurse in Kansas.
      - Malpractice insurance.
      - Conduct a general review of policies and procedures on a one-by-one basis.
3. Month 1 Goals: At the end of a month the new employee will be performing some functions in a routine manner. During this time the new employee will make observations about the organizational functions and should be encouraged to share creative ideas with the supervisor and workgroup. Month 1 should reflect a continued, structured effort to help the new employee gain the knowledge and skills essential for the position. This is an excellent time to provide a formal, but unofficial, evaluation of the employee to further identify needed development areas and to provide feedback regarding progress.
   a. Activities to be accomplished by the end of Month 1 include:
      - Training needs assessed and arrangements made to meet these needs.
      - Assess routine reports and documentation for proper use.
      - Employee understands performance appraisal system and standards to be met.
      - Employee has become familiar with the role of the State Department of Health and Environment.
      - Evaluation meeting held.

4. Six Month Goals: By the end of six months employment, the employee should have been exposed to all agency program area and should have experienced in-dept training for the programs of involvement. Keep in mind that training is a continuous function. The single most important factor related to the orientation/training of a new employee is that effective communication and feedback should be on going.

   b. Activities of the first six months:
      - Training needs completed or formally planned.
      - Orientation to all program areas.
      - Information, evaluation, and feedback culminating in a formal evaluation at the end of six months.
      - Attendance at KDHE orientation programs planned.

Personnel Policies

The policy manual is a medium of communication. Its purpose is to define and explain the relationship between your employees and the agency. The manual presents the rules and procedures you expect all employees to observe. It explains your standards of appropriate conduct. It spells out the benefits and privileges you offer in return for good work – along with the penalties for poor performance.

It is a communications tool for your managers and supervisors. Even though you take the time to develop policies and procedures, you could be subject to a lawsuit if they are not followed. Courts have found that a policy manual can be a contract. When an employee violates a company policy, there is a procedure for corrective action. If the company does not follow its own procedure, it may have violated the terms of a contractual relationship with the employee.

The nature of your organization, the types of people you employ, and the way you manage will produce an overall organizational culture. Without policies, you leave the definition of that culture to chance. With the help of a policy manual, you can exercise more direct control over exactly what the relationship between the people and the organization will be.

As an instrument of communication, a well-written manual can serve many very valuable purposes, which include building loyalty and morale, illustrating the benefits of working for you, and providing a reliable explanation of policies and procedures.

Before proceeding with the writing of a personnel policy manual, clarify your motives. The following are possible reasons for developing a policy manual:

1. To present information on policies and practices
    - Organizational structure
    - Work rules
    - Pay and benefits
    - New employee orientation
    - Disciplinary procedures
    - Performance appraisal and career development
    - Employer services and activities

2. To build morale and team spirit
    - Create pride in the organization
    - Present a complete picture of the benefits your organization provides
    - Answer routine questions

3. Meet legal and procedural requirements
    - Federal, state, and local employment practice laws
    - Health and safety laws

To complete the policy planning process, identify the specific topics you want to cover in policy statements. The following is a comprehensive list of policy subjects for which to choose.

1. Introduction to the organization
    - Welcome letter from senior official
    - History and philosophy
    - Organization, divisions, and departments
    - Products, services and philosophy
    - General communication
    - Agency publications, bulletin boards and other communications media
    - Ethical standards of the organization
    - Conflicts of interest

- Confidentiality
- Working hours
- Employee rights
- Health and safety requirements

2. Dispute resolution system
   - Handling grievances
   - Counseling services

3. Hiring policies
   - Affirmative action
   - Equal employment opportunity
   - Recruiting
   - Probationary periods
   - New employee orientation

4. The disciplinary program
   - Disciplinary procedures
   - When exceptions are in order

5. Performance appraisal
   - Frequency and method
   - How performance is measured
   - How the results affect retention, pay and promotion

6. Progressive discipline
   - Typical offenses and penalties
   - Normal steps in the process
   - Guidelines for exceptions

7. Discharge procedures
   - Guidelines for decisions
   - Procedural steps
   - Security and confidential information
   - Obtaining releases
   - Out placement services

8. Work rules and standards
   - Hours, regular and overtime
   - Attendance standards and notification requirements
   - Vacation, sick leave, and personal time off
   - Lunch and break periods
   - Smoking
   - Solicitation and visitors
   - Telephone use
   - Alcohol and drug policies
   - Security requirements
   - Lunches, travel, and reporting expenses
   - Care of agency property
   - Waste control and prevention
   - Security procedures and equipment
   - Dress and appearance
   - Outside employment

- Sexual harassment
- Weapons

9. Pay policies
   - Paydays and payroll periods
   - Salary administration
   - Payroll deductions
   - Overtime and shift premiums

10. Benefits
    - Available benefits
    - Eligibility standards

11. Other personnel policies
    - Jury duty
    - Leaves of absence
    - Sick leave
    - Bereavement leave
    - Military leave
    - Employment classification
    - Assignments and transfers
    - Layoffs and recalls

In a policy manual, outdated information can easily be worse than no information at all. If you are to maintain successful communication with your employees, it is important that you keep the policy manual current with periodic updates.

References

The Company Policy Manual (1990). Harper Business.

Klinger, D.E. & Nalbandian, J. (1993). Public Personnel Management Contexts and Strategies. 3rd Edition. Englewood Cliffs, NJ: Prentice-Hall, Inc.

Scheer, W.E. (1985). The Dartnell Personnel Administration Handbook. Dartnell Press.

Fair Labor Standards Act

The Fair Labor Standards Act (FLSA) provides minimum wage, overtime pay, record keeping, and child labor standards. Some employees are specifically exempted for the requirement of the Act. Bona fide executive, administrative, and professional employees and outside sales people are exempt from the minimum wage and overtime requirements of the Act if they meet the tests set for each category. Whether employees are exempt depends on their duties and responsibilities and the salary paid.

The minimum weekly salary specified in each category is one of several tests applied in determining the exemption; it is not a minimum wage requirement. No employer is required to pay an employee the salary specified in the regulation, unless the exemption is claimed.

Any employee who is paid at least the minimum weekly salary specified and who also meets all of the duties and responsibilities specified is exempt from the minimum wage and overtime pay requirements of the law. A title does not make an employee exempt; nor is the employee exempt simply because payment on a salary rather that an hourly basis.

For specific questions about the statutory requirements, contact Wage and Hour Division's nearest office. Give detailed information regarding the question, since coverage and exemption depend on the facts in each case.

Wage and Hour Division contact for Kansas:
316-269-7166 or 913-551-5721

Americans with Disabilities Act

The Americans with Disabilities Act of 1990 (ADA) provides a national mandate for the elimination of discrimination against individuals with disabilities. The ADA includes five titles, which address the following areas:

Title 1 – employment
Title 2 – public services and transportation
Title 3 – public accommodations
Title 4 – telecommunications
Title 5 – miscellaneous

Title 1 includes the following employment provisions:

- Employers may not discriminate against an individual with a disability in hiring or promotion if the person is otherwise qualified for the job.
- Employers can ask about one's ability to perform a job, but cannot inquire if someone has a disability or subject a person to tests that screen out people with disabilities.
- Employers will need to provide "reasonable accommodation" to individuals with disabilities. This includes steps such as job restructuring and modification of equipment.
- Employers do not need to provide accommodations that impose an "undue hardship" on business operations.

Title 2 addresses discrimination against the disabled by state and local governments, as well as the accessibility of transportation systems.

Title 3 mandates changes in the way public accommodations and commercial facilities must be adapted or constructed. Both existing buildings and new construction must meet requirements for accessibility.

Title 4 requires companies offering telephone service to the general public to offer telephone relay services to individuals who use telecommunications devices for the deaf (TDDs) or similar devices.

All employers with 15 or more employees were required to comply with ADA effective July 26, 1994.

For specific details regarding ADA requirements, contact the following resources:
Kansas Department of Human Resources 785-296-1722
U.S. Dept. of Justice, Civil Rights Division 202-514-0301

Family and Medical Leave Act of 1993

The purpose of the Family and Medical Leave Act of 1993 (FMLA) is to balance the demands of the workplace and the needs of families in a manner that accommodates the legitimate interests of employers. FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to "eligible" employees for certain family and medical reasons. Employees are eligible if they have worked for a covered employer for a least one year, and for 1,250 hours over the previous 12 months, and if there are at least 50 employees within 75 miles.

Reason for Taking Leave:
Unpaid leave must be granted for any of the following reasons:

- to care for the employee's child after birth, or placement for adoption or foster care;
- to care for the employee's spouse, son or daughter, or parent who has a serious health condition or
- for a serious health condition that makes the employee unable to perform the employee's job.

At the employee or employer's option, certain kinds of *paid* leave may be substituted for unpaid leave.

Advance Notice and Medical Certification:
The employee may be required to provide advance leave notice and medical certification. Taking of leave may be denied if requirements are not met.

- The employee ordinarily must provide 30 days advance notice when the leave is "foreseeable".
- An employer may require medical certification to support a request for leave because of a serious health condition, and may require second or third opinions (at the employer's expense) and a fitness for duty report to return to work.

Job Benefits and Protection:

- For the duration of FMLA leave, the employer must maintain the employee's health coverage under any "group health plan."
- Upon return form FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.
- The use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

Unlawful Acts by Employers:
FMLA makes it unlawful for any employer to:

- interfere with, restrain, or deny the exercise of any right provided under FMLA;
- discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relations to FMLA.

Enforcement:

- The U.S. Department of Labor is authorized to investigate and resolve complaints or violations.
- An eligible employee may bring a civil action against an employer for violations.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement, which provides greater family or medical leave rights.

For additional Information:
Contact the nearest office of the Wage and Hour Division, listed in most telephone directories under U.S. Government, Department of Labor. Wage and Hour Division contacts for Kansas are:

316-269-7166 or 913-551-5721

References

Your Rights Under the Family and Medical Leave Act of 1993. (1993, June). Washington, DC: U.S. Department of Labor Employment Standards Administration, Wage and Hour Division. WH Publication 1420.

Grievance Procedures

All agencies should have a written grievance procedure policy to provide a formal process for expressing dissatisfaction with any aspects of working conditions or actions which may jeopardize an employee's ability to perform their job in an efficient manner or within a reasonably acceptable working environment. Such procedures are provided to assure the opportunity for prompt and fair resolution of grievances in order to maintain a positive working environment. Public health or similar departments or agencies governed by boards will be subject to grievance procedure policies set out by the large agency, and if specific policies are listed by the LHD, it is important that they not conflict with those of the umbrella agency. Employees covered under a memorandum of agreement that includes a grievance procedure may usually choose the policy they wish to follow in filing their grievance. Once filed, their decision cannot be changed. Ideally, employees should resolve differences of opinions, situations of unfavorable working conditions and general employment related problems through normal communication channels and appropriate organizational structure routes of reporting. When the employee feels, however, that such problems have not and cannot be resolved in this manner, they should proceed with the specific grievance procedure.

The grievance policy should specify the appropriate method for filing a grievance (oral, written), the proper sequence of steps to be followed towards a resolution or final decision, subject matter limitations, time limitations, and general area of responsibility. The policy should also provide protection for employees filing the grievance, such that they are unimpeded and free from restraint, coercion, discrimination or reprisal. An alternate channel should be specified if the employee feels the issue is one that cannot be discussed with the supervisor, such as discrimination. How the policy will be made available to all employees should be addressed (bulletin boards, policy book, specific forms).

The grievance procedure is usually written in steps with specific instructions and time frames attached to each. The process goes through ascending levels of hierarchy if not reconciled at each lower level. A chart is a helpful attachment. If a grievance review committee is to be used, it should be stated as to how and of whom the committee will be formed, and the duties of the committee. The final decision-maker should be identified and right of appeal addressed.

Time limitations should be identified for filing a grievance and for response. This insures prompt action by all parties involved. If the time is in "working days," it should so state. Extensions, penalties and actions to be taken if time limitations are not met should be specified.

Grievance subject limitations should identify the reasons for which employees may and may not file grievances. One definition of grievance is "a statement of dissatisfaction over any condition of work which allegedly has an adverse effect on the employee." A grievance generally should not include matters for which another method of settlement or an appeal procedure is already established.

Time on duty/off duty should address whether time spent on grievances will be considered on duty for pay purposes.

General areas of responsibility should be outlined for employees, supervisors and agency administrators, and personnel offices involved in the grievance process.

References

Kansas Department of Health & Environment: Secretary's Policy 93-025 (1994). "Grievance Procedures."

Kansas Department of Health & Environment (1997). "Grievance Procedure Policy."

Americans with Disabilities Act of 1990: Title II.

Sexual Harassment Policy

A written policy regarding sexual harassment should be in place to comply with EEOC Guidelines on Discrimination Because of Sex. The policy should specifically prohibit sexual harassment of the agency's employees in any form in the workplace and in other employment-related activities. Such policy should outline the agency's proposed actions, up to and including dismissal, to insure that the work environment is free of sexually harassing behavior. It should also protect and forbid retaliation against any employee who exercises the right to report sexual harassment.

A statement may be included to address an individual's sexual orientation. One example of such statement is that "an individual's sexual orientation is not a criterion either for becoming an employee or remaining an employee of the agency. Performance evaluation and promotion status are based upon demonstrable job performance and behavior. An individual's sexual orientation is strictly personal and information about this matter should not be sought by agency personnel."

Sexual harassment as defined by law, is unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature. Derogatory sexual remarks also constitute sexual harassment when:

A. submission to such conduct is made, either explicitly or implicitly, a term or condition of an individual's employment;

B. submission to or rejection of such conduct by an individual is used as the basis for employment decisions affecting the individual; or

C. such conduct has the purpose or effect of interfering with an individual's work performance, or creating an intimidating, hostile, or offensive work environment.

Some behaviors, which could be construed as sexual harassment, include, but are not limited to:

A. the continual or repeated verbal abuse of a sexual nature, including, but not limited to, graphic commentaries about an individual's body, sexually suggestive objects or pictures in the workplace, sexually degrading words used to describe the individual, or propositions of a sexual nature;

B. the threat or insinuation that lack of sexual submission will adversely affect the individual's employment, wages, advancement, assigned duties or shifts, or other conditions that affect the individual's livelihood;

C. jokes, graffiti, and/or display in the workplace of sexually suggestive calendars and posters which contribute to a hostile or offensive working environment; and

D. sexual conduct, which indirectly affects the terms, conditions and opportunities of employment of another individual or creates a hostile work environment.

The procedure for filing a sexual harassment complaint should be outlined in the policy. The person with whom the report is to be filed, time frames for filing and investigation, documentation and confidentiality for both the person who files, and the alleged perpetrator must be addressed. A progressive discipline plan should be in place. Responsibilities of employers and employees to carry out the policy may be delineated.

References

Kansas Department of Health & Environment: Secretary's Policy 93-014 (1994). "Sexual Harassment."

Kansas Department of Health & Environment (1997). "Sexually Harassment Policy."

Personnel/Health Files

Personnel files should be kept in the facility for all employees of that facility. A shell type file may also be kept at the county clerk's office in the case of local health departments if that is done for other county departments, but this file will not have detailed performance information.

A separate health file for each employee should also be maintained in the facility. This file is confidential.

Examples of items to be included in personnel filed:

- Employee application
- Every evaluation
- Signed statement that employee has read policies and procedures. Update yearly or when policies and procedures change.
- Signed orientation checklist
- Continuing education and in-services attended
- Signed position description
- Copy of pertinent licenses or certificates (update)
- Merits, warnings, reprimands

Examples of items to be included in a health record:

- Initial and periodic TB skin test results
- Immunization record (updated)
- Disability statements

Staff Development System

Each local health department should be able to demonstrate that a staff development system is in place and that performance based training programs relative to the needs of the agency are available to the employees of the agency.

There are three components to a staff development system:

Orientation: activities designed to bring the newly hired employee to a basic level of safe and competent functioning within the agency. Normally, this process is begun with the first day of employment and will continue over several days to even months. Typical activities are: review of policies and procedures, review of personnel policies, discussion about mission and goals of agency, introduction to other personnel, orientation to physical layout of agency, review of safety policies, and assessment of skills according to a skills checklist developed within the agency. Orientation can include time spent with preceptors if such a system is in place.

In-service: ongoing educational activities designed to assist the employee to perform the job according to current standards. Typical activities are: in-services to present new drugs, procedures, or equipment; review of existing procedures; CPR recertification; and updates on forms or policies. Typically, these are required activities with documented participation. There is no continuing education credit for in-services.

Continuing education: professional education beyond the basic, designed to further knowledge and skills and to affect attitudes. Typically this will take the form of workshops, symposia, seminars, and professional group conferences. Normally, persons expect to earn continuing education credit for these activities. Other, less frequently mentioned activities are: further academic education, a planned program of journal reading, and presenting workshops. These latter may or may not earn continuing education credit.

In planning a staff development system, which includes all three components, a balance of needs and resources must be achieved. Needs must be prioritized according to the individual agency and resources expended to meet those priority needs first.

Employee Evaluation/Performance Appraisal

Employee evaluation or performance appraisal provides employees with feedback on their work, leading to greater clarity regarding organizational expectations and to a more effective channeling of employee ability. It may also lead to organizational or allocation decisions regarding promotion and pay. Unfortunately this evaluation is frequently a source of tension in the employee-employer relationship.

There are several purposes of employee evaluation/performance appraisal:

1. Communicate management goals and objectives to employees.
2. Document accomplishments and provide appropriate praise for good performance.
3. Motivate employees to improve their performance.
4. Distribute organizational rewards such as salary increases and promotions equitably.
5. Conduct personnel management research.

Criteria may be person-based, performance-based, or occasionally a mixture of the two. Person-based systems assess an employee's personality traits, characteristics, and aptitudes and often lead to very subjective assessments. Performance-based systems measure each employee's behaviors against previously established behaviors. For validity and legal reasons, the trend is toward performance related behaviors. Separate performance standards should be developed for each employee or class of similar positions and these standards must be altered periodically to meet changes in organizational objectives, resource allocation, or environmental constraints.

Several appraisal methods exist and examples shown will identify the method used. Graphic rating, ranking, and forced choice are most commonly used in person-based ratings. Of these, the forced choice technique is probably the most valid and least biased because the rater does not know the preference of the person who wrote the evaluation. Essay, objective, critical incident, and behaviorally anchored rating scales lend themselves toward performance-oriented criteria.

An employee's performance may be rated by a number of people. The immediate supervisor must commonly assesses the performance of subordinates. Supervisory ratings reinforce authority relationships but are easily biased. Self-ratings have value in promoting honest discussion between supervisor and employee but studies have shown some self-ratings to be highly inflated while others were just the opposite. Peer ratings are occasionally used also.

In order for an appraisal system to be effective, several things should be considered. First, it may be wise to utilize separate systems for separate purposes. In reward allocation the rater becomes a judge, but when the purpose is to improve employee performance, the supervisor is more of a counselor or facilitator. Second, the rater should have the opportunity, ability, and desire to rate employees accurately. Third, occupation specific job descriptions should include performance standards as well as duties, responsibilities, and minimum qualifications, thus tying together job analysis and performance appraisal. Fourth, the appraisal should capture the employee's motivation for self-improvement with such objectives as promotion and career planning.

Job Descriptions

The job description should be a general outline of all the duties expected of the employee. One way to organize the job description is by categorizing the areas of responsibility for the position and then list specific duties and tasks beneath each category. Job descriptions should be unique to the agency because each agency or organization is different and the job description should accurately reflect the job you expect the employee to do. It should be detailed to the extent that it will provide a clear picture of the job to someone not familiar with it, but general enough to provide a proper perspective by avoiding the extraneous.

The terms "position description" and "job description" are often used interchangeably. Technically, however, a **position** is a collection of duties constituting the total work assignment of a single worker. There are as many positions as there are workers in the country. A **job** is a group of positions, which are identical with respect to their major or significant tasks. There may be one or many persons employed in the same job. A job description is a brief description of major duties and responsibilities along with additional descriptions of key job behaviors, working conditions, minimum training, and required experience. Once written, the job description must be date and signed by the supervisor and employee. It must be reviewed and dated annually.

The job description should include:

1. A position summary or brief statement of the primary function(s) or purpose of the job.

2. A "work performed" section with a brief but complete description of duties and responsibilities prioritized for importance.

3. Organization relationships such as supervision, leadership, personal relations, contacts, problem solving, decision making, and accountability.

4. Working conditions or uncommon circumstances including environmental conditions, physical or special job demands.

5. Identifications of essential and primary functions.

6. Identification and documentation of minimum qualifications for the job, including knowledge, abilities, skills, experience, and education.

7. List standards of performance if those are in place.

Several examples of job descriptions have been provided for personnel commonly employed in a local public health agency. Remember that these are guides only and that the actual job description should be individualized for each agency.

Sample Job Descriptions

Local Health Department Administrator

Scope of Work

- Collects data and information about the health needs of all segments of the jurisdiction and, with the Board and community, develops plans, services or programs to meet health needs.
- Works with the medical consultant in establishing medical and clinical programs and procedures including the evaluation of statistics and data on health status of the community.
- Establishes policies and maintains programs of the agency, as determined by Board policy, as well as applicable state statutes and federal regulations.
- Initiates and participates in community programs to provide health promotion and education information and services.
- Prepares annual operating budget, procures grant and private funds with Board approval, and maintains and reports all financial records and transactions.
- Develops on-going strategic planning procedures, cooperates with existing agencies and groups providing health related services, and coordinates health department activities with these whenever possible.
- Procures staff and provides for their training and supervision. Directs and supervises the maintenance of material, supplies, and equipment for the agency.
- Maintains a liaison with members of the federal, state, and local governments, representatives of private business and the public.

Minimum Education

- Basic preparation in health sciences or related field.
- Graduate preparation in public health, administration, or health science.

Special Training or Education - Masters of Public Health preferred.

Special Knowledge, Skills, Abilities

This is a highly skilled administrative and professional position, which assumes overall direction, supervision, authority and management for the public health agency subject to the approval of the Board of Health. Work involves knowledge and capacity for community interaction including planning, organizing, coordinating and networking with other organizations services, health and social programs within the jurisdiction and the state. Considerable independent judgment is necessary to discharge the responsibilities of the position.

Experience

Academic preparation must be supplemented by five years experience in administration of public health programs and policies. Increasingly responsible experiences in public health administration, budgeting and financial managements, personnel supervision and communication.

JOB DESCRIPTION

Public Health Administrator

Position Summary

This is a highly skilled administrative and professional public health position, which assumes the overall direction, supervision, and management of the agency subject to the policy and approval of the County Commission. The Administrator works directly with the Medical Consultant in establishing medical and clinical programs and procedures in which medical protocols are involved. The work involves planning, organizing, and directing the public health services, coordinating and networking with other organizations and services, developing and interpreting policies and procedures, and maintaining acceptable standards. Supervision is exercised over all employees of the agency. Although work is preformed according to federal and state guidelines, the employee in this position must exercise considerable independent judgment when carrying out the responsibilities of the position. Work is reviewed by the County Commissioner or their designated representative, through conferences, reports, and evaluation of results obtained.

Duties and Responsibilities

- Establishes and administers the programs and services of the agency, within the parameters of the policy set by the County Commission, as well as applicable state statutes and federal regulations.
- Keeps an accurate record of all transactions of the agency, including clients served, dollars spent, activities completed, and other pertinent statistics.
- Prepares the agency's annual operation budget, procures grant and private funds, and oversees and evaluates all contracts for services necessary to provide health programs.
- Develops on-going strategic planning procedures to collect data and information about health needs of all segments of the county, and to propose solutions with adaptation of services or new programs to meet the defined needs.
- Works with the Medical Consultant in establishing medical and clinical programs and procedures for the agency, including the evaluation of statistics of the incidence of disease and occurrence of unusual diseases.
- Provides input and support for the activities of the health department advisory committee. Cooperates with existing agencies and groups providing health related services and coordinates health department activities with them whenever possible.
- Procures staff and provides for their training and supervision. Directs and supervises the maintenance of materials, supplies, and equipment for the agency.
- Assumes personal responsibility to keep informed of current changes affecting public health practice.

Personal Relations/Contacts

- Performs liaison duties with members of the federal, state, and local government, representatives of private business, and has continual contact with the public.
- Attends community health related activities and serves on various community advisory boards which address public health issues.
- Initiates and participates in community programs to provide health promotion and education information and services.

Consequences of Actions and Decisions

- Extensive problem solving is a factor in this position. Problems include planning and implementing new health programs, modifying programs due to budget cuts, and determining adequate staffing and scheduling.
- Duties require a high degree of concentration because of the many factors, which must be considered and weighed before a decision can be made. This position requires extensive planning, developing, and coordinating programs as well as directing and supervising staff.

- Responsibility exists for planning, developing, and directing the administration of public health program through established standards for the quality assurance process, reports, and evaluation of results. Also responsibility occurs for the budgetary control of the agency and participation in the development of the departmental budget process.

Qualifications

- Education:
    - Baccalaureate degree from an accredited four-year college or university in public administration, health sciences, or related fields.
    - Graduate degree in public health, administration, or health science. Masters in Public Health (MPH) preferred.

- Experience - Academic preparation must be supplemented by three years increasingly responsible experience in administration of public health programs and policy.

- Special knowledge, skills and abilities - Knowledge of public health theory and practice and of their application. This is a highly skilled administrative and professional position, which assumes overall directions and supervision, authority and management of the public health agency. Work involves knowledge and capacity of community interaction including planning, organizing, coordination and networking with other organizations, services, health and social programs within the jurisdiction and the state. Considerable independent judgment is necessary to discharge the responsibilities of the office. Knowledge of fiscal management including budget and grant preparation. Excellent verbal and written communication skills required.

JOB DESCRIPTION

Local Health Officer

The Local Health Officer: The duties of the Local Health Officer are authorized by state law (K.S.A. 65-202) and local resolution and ordinances and are under the direction of the Board of Health. The Health Officer works cooperatively with the Administrator of the Local Health Department to assure the public's health. The responsibilities of the Health Officer include the following:

A. Enforce compliance with pertinent local and state statues to assure protection of the health of the public.

B. Assure appropriate, mandated reporting of diseases.

C. Establish an active surveillance program for communicable diseases and other health concerns assuring timely investigation, collection of data, and implementation of appropriate epidemiological interventions.

D. Establish health policy and issue public statements about the public's health.

E. Educate citizens, physicians, other health care providers and governing bodies regarding public health concern, threats, and recommended interventions.

F. Assure timely and appropriate response to public health emergencies.

G. Work cooperatively with the Kansas Department of Health and Environment to assure effective communication, planning and interventions to protect the health of all Kansans.

H. Assess and monitor public health needs and changes in the health care system and establish and integrate appropriate public health programs and population-focused prevention into the community's total health care system.

Job Description

Nursing Supervisor

SUPERVISED BY: Administrator

Position Summary

This is a highly skilled professional public health nursing position, which includes direct nursing services in clinic and community settings, as well as administrative, supervisory, and consultive responsibilities. Work involves planning, organizing, and directing the local public health nursing program. This work includes coordination of the public health and nursing program with the programs of other community organizations involved with health issues and services, developing and interpreting nursing policies and procedures, and maintaining acceptable standards of public health nursing. Supervision is exercised over staff of professional and licensed nursing staff, clerical, receptionist, and lay home visitors. Work is performed with considerable independence under the general direction of an Administrator and is reviewed through conferences and reports for results achieved.

Duties and Responsibilities

Essential Job Functions

- Participates in planning and operation of public health clinics; interviews clients, performs diagnostic tests, gives prescribed treatments and immunizations, records data, makes necessary referrals, and participates in coordinating the total clinic service in the interest of the client.
- Assists in epidemiological control and studies and in the interpretation of communicable disease control measures.
- Plans and develops the administrative policies and procedures and the nursing aspects of specialized public health programs and reviews their effectiveness.
- Oversees the general operation and insures adequate coverage of nursing services provided in all of the agency's clinics and special programs.
- Develops and maintains written protocols and standing orders for nursing services, as well as reviewing and revising all nursing service forms.

Supervision/Leadership

- Functions with little or no direct supervision, but with job related decisions occasionally reviewed by the Administrator.
- Directs the operations of the agency in the absence of the Administrator.
- Recruits and hires community health nurses, lay visitors, and clerical personnel in conjunction with the Administrator.
- Assumes considerable responsibility for the orientation, guidance, and supervision of new staff.
- Supervises and evaluated the work performed by the nursing staff, home visitors and clerical personnel.

Personal Relations/Contacts

- Frequent contact with state and county departments, community businesses and health related agencies, and continual contact with the general public.
- Provides consultation to public health nurses or public organizations for program development and coordinates program activities with those of other agencies or public organizations.
- Initiates and participates in community programs to provide health promotion and education information services.

Consequences of Action and Decisions

- Problem Solving - A high degree of problem solving is involved with this position. Problems include planning, implementing, and coordinating health programs and determining appropriate staffing and scheduling.

- Decision Making - Duties require extensive concentration due to the many factors, which must be considered before a decision can be make. Consequences of decisions are significant as work may rarely be reviewed and errors may cause major program failure or a high degree of confusion.
- Accountability - Responsible for planning, developing, and directing the nursing aspects of the public health programs through established standards, the quality assurance process, reports, and evaluation of results.

Working Conditions

- Environmental Conditions - The work environment involves normal everyday hazards and discomforts typical of offices and clinic operations. This position may also be subject to moderate travel and adverse weather conditions.
- Physical Demands - Possible adverse working conditions exist in this position including exposure to communicable diseases and the lifting of clients and equipment.
- Special Job Demands - Maintain current Assessment Certification, which includes Vision, Hearing, and Denver II Certifications. Maintain current CPR Certification. Ability to work with clients of all ages including children. Ability to work with non-English speaking persons. Subject to coming into contact with irate/ difficult persons.

Minimum Qualifications

- Knowledge - Knowledge of public health nursing theory and practice. Knowledge of supervisory practices and techniques. Knowledge of consultation and leadership techniques. Comprehensive knowledge of public health related issues.
- Abilities - Ability to plan and implement public health programs and services to meet community and individual needs. Ability to provide skilled nursing care based on scientific principles, basic behavioral concepts, and intelligent professional judgment.
- Skills - Able to administer injections and treatments and to perform screening tests utilizing the correct procedures and the correct use of equipment. Good interpersonal, oral, and written communication skills.
- Experience and Education
    - Graduate from an accredited four-year college or university with a degree in nursing, supplemented by one year of experience in professional nursing and one year of experience in public health nursing.
    - Graduate from an accredited non-baccalaureate professional nursing school supplemented by three years experience in public health.
    - A master's degree in nursing or completion of an accredited nurses practitioner program may be substituted for a maximum of one year of the required professional experience of public health nursing.

Currently registered in the State of Kansas or have a temporary permit to practice issued by the Kansas State Board of Nursing.

Job Description

Staff Nurse

SUPERVISED BY: Nurse Administrator or Supervisor

Position Summary

This is a general public health nursing position with work involving direct nursing services for clients in open and satellite clinics. Duties include immunizations, family planning, STD, child health and adult health nursing programs. Work includes planning for and carrying out public health nursing programs and coordinating these programs with related services. Work is performed with latitude for professional independence and in accordance with established agency policies and procedures under general direction of the Nurse Administrator and reviewed through reports and conferences for results achieved.

Duties and Responsibilities

Essential Job Functions

- Evaluates each client's immunization status and determines appropriate action based on written protocols.
- Responsible for obtaining laboratory specimens for the screening and/or the diagnoses of communicable diseases.
- Provides screenings for hypertension, diabetes, anemia, cholesterol, and urinalysis and determines appropriate action based on referral criteria.
- Performs and reads Mantoux skin testing for screening in tuberculosis control.
- Screens for head lice and determines appropriate action based on written protocols.
- Provides health education regarding communicable disease, family planning methods, and sexually transmitted diseases to parents, children and the general public.
- Provides Physical Assessments including vision, hearing, Denver II screenings, and laboratory tests with appropriate referrals and follow-up.
- Counsels the client and family in meeting health needs including health promotion, nutrition, and illness care.

Supervision

- Moderate supervision is provided by the Nurse Administrator (or the Nursing Supervisor depending on the agency organization). Employee may have supervisory responsibility over subordinate personnel.

Personal Relations/Contacts

- Occasional contact with other county departments and health agencies, but continual contact with the general public.

Consequences of Action and Decisions

- Problem Solving - Moderate problem solving is a factor in this position as the employee works under agency standards and written protocols with supervision as needed.
- Decision Making - Moderate decision-making is a factor in this position. Decisions include determining when to refer clients to other health care providers and determining how to coordinate clinic functions with other agency activities.
- Accountability - Employee is responsible for the general functioning and organization of the clinic operation and specifically for the appropriate nursing care, referral, and follow-up of individual clients.

Working Conditions

- Environmental Conditions - The work environment involves moderate hazards, risks, or discomforts. Exposure to communicable diseases requires infection control measures. Minor to moderate injuries are possible from immunization and specimen collection procedures.
- Physical Demands - This work requires moderate physical exertion and the employee is generally confined to a work area. Possible adverse working conditions exist in this position including the lifting of clients and equipment. Subject to fluctuating volumes of people seeking services.
- Special Job Demands - Maintain current Assessment Certification, which includes Vision, Hearing, and Denver II Certifications. Maintain current CPR Certification. Ability to work with clients of all ages including children. Ability to work with non-English speaking persons. Subject to coming into contact with irate/difficult persons.

Minimum Qualifications

- KNOWLEDGE - Knowledge of professional nursing principles and practices, public health nursing theory and practice and of their application. Comprehensive knowledge of public health related issues.
- ABILITIES - Ability to provide skilled nursing care based on scientific principles, basic behavioral concepts, and intelligent professional judgment. Ability to manage a well functioning clinic operation and to provide assessment and nursing care to individual clients.
- SKILLS - Able to administer injections and treatments and to perform screening tests utilizing the correct procedures and the correct use of equipment. Good interpersonal, oral and written communication skills.
- EXPERIENCE and EDUCATION - Graduate from an accredited nursing school with at least one year of experience in public health nursing.
- Currently registered in the State of Kansas or have a temporary permit to practice issued by the Kansas State Board of Nursing.

Secretary/Bookkeeper

Position Summary

Under the supervision of the county health administrator, the secretary/bookkeeper is a non-exempt position under FLSA who performs responsible bookkeeping, clerical and office management duties. The employee in this position is frequently expected to act independently in answering citizen inquiries, typing correspondence, preparing billings, scheduling appointments and maintaining the office in good working order.

Essential Functions

- Enters information in the computer and generates reports
- Maintains all department computer files
- Collects and sorts mail
- Types, copies, distributes and files correspondence, memorandum and minutes
- Answers the telephone and assists patients
- Prepares and sends out billings to insurance companies and patients
- Prepares claims and submits them for Medicals, Medicare and other insurance
- Receives payment of billings
- Makes necessary entries on client ledger
- Deposits receipts
- Schedules appointments
- Monitors office supplies and orders supplies when necessary
- Prepares financial statements and account reports for county clerk's office
- Records monthly expenses and receipts and maintains records
- Files charts, billing and correspondence
- Maintains immunization schedules and records and provides accurate information to clients
- Provides the public with health and resource information

Marginal Functions

- Other related duties which are similar, related or a logical assignment to the position

Minimum Qualifications

- On to three years of clerical and bookkeeper experience is required
- High school diploma or GED required.

Skills: Knowledge of office policies and procedures, mathematics and bookkeeping principles. The ability to receive, interpret and follow instructions. Excellent interpersonal and communication skills required. The ability to gather, interpret and analyze records and data and present data in report form. The ability to maintain records in complete and accurate order. Must maintain patient confidentiality in all areas of work.

Equipment Used: The ability to operate a telephone, typewriter, calculator, computer and other related office equipment.

Supervision: The employee in this position does not supervise other employees.

Physical Requirements: Work is sedentary in nature and is performed at a desk or counter the majority of the time. May require lifting, carrying or moving items weighting up to 20 pounds occasionally. The ability to express or exchange ideas by means of communication. Conveying detailed or important instructions to other workers and the general public. Picking, punching, typing or otherwise working primarily with fingers rather than the whole hand or arm as in handling. The ability to enter large quantities of information in the computer. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions of this position.

Working Conditions: Work is performed in an office environment and no adverse working conditions exist in this position.

Job Description

Administrative Assistant

Position Summary

Under the administrative supervision of the county health administrator, the administrative assistant performs clerical tasks of moderate complexity and variety. Work in this position involves working directly with the administrator assisting in clerical work; grant writing, record keeping, publicizing monthly newsletters, and other duties as deemed necessary by the administrator. The Administrative Assistant will also assist as Daycare Assistant Surveyor by assisting the daycare surveyor in daycare investigations, surveys, grant writing, monthly new letters and filing.

Duties and Responsibilities:

- Computer documentation
- Aid in writing grants
- Helps with quarterly report writing and processing
- Work directly with public on occasion
- Assist at reception desk in absence of receptionist
- Answer phone
- Types correspondence and does filing as needed
- Develop monthly health department calendar
- Routine re-licensing inspections and compliance checks for daycare home
- Do annual day care surveys and assist in daycare investigations
- Setup daycare educational classes and assist in training when needed
- Do monthly daycare newsletter
- Keep current on daycare regulations and laws
- Other duties as deemed necessary by the health department administrator

Qualifications for this Job:

- Associate degree
- Proficient in computer operations and skills
- Understanding of general, accounting and grant writing
- Have good working public relations
- Knowledgeable with computer graphic skills
- Some knowledge of insurance billing and processing of claims
- Associate or greater degree in Child Care and Guidance or Equivalent Associate degree

Clerk II

Position Summary

Under the supervision of the county health administrator, the clerk II performs responsible bookkeeping, clerical and secretarial duties. The employee in this position is frequently expected to act independently in answering citizen inquiries, typing correspondence, preparing billings, scheduling appointments and maintaining the office in good working order. The Clerk II acts as receptionist, answering the telephone and directing inquiries to the proper authority.

Examples of Work

- Collects and sorts mail
- Types and files correspondence
- Records statistics and prepares reports on all programs of the department
- Answers the telephone and assists patients
- Makes necessary entries on client ledger
- Schedules all WIC appointments and distributes vouchers
- Types and forwards department purchase orders
- Types and submits claims for Medicaid clients
- Deposits receipts
- Schedules appointments
- Monitors office supplies and order supplies when necessary
- Maintains records and reports and works with clients on WIC program
- Other related duties as deemed necessary or as required

Position Requirements

Experience: Two to three years of clerical and bookkeeping experience is required. Employee is expected to have acquired the necessary information and skills to perform the job reasonably well after six months in the position.

Education: High school diploma or GED required. Supplemental courses in office practices and bookkeeping preferred.

Skills: Knowledge of office policies and procedures, mathematics and bookkeeping principles. Working knowledge of computer data entry and report generation. Good interpersonal, oral and written communication skills. The ability to operate a typewriter, calculator and other related office equipment.

Problem Solving: Problem solving exists in this position. Problems include coordinating patient scheduling in the WIC Program and obtaining necessary information from patients.

Decision Making: Limited decision-making exists in this position. Decisions include determining when to schedule appointments and when to notify a nurse of problems.

Accountability: Employee is responsible for funds collected in the office and the distribution of WIC vouchers. Employee does not have budgetary control of the department and does not participate in the annual department budget process.

Supervision: Supervision is provided by the county health administrator and county health nurse. Employee does not have supervisory responsibility over subordinate personnel.

Personal Relations: Occasional contact with other county departments and continual contact with the general public.

Working Conditions: No adverse working conditions exist in this position.

Physical Requirements: The ability to express or exchange ideas by means of verbal communication. Conveying and receiving detailed or important verbal instructions to and from other workers and the general public.

Receptionist/Clerk I

Position Summary

Under the supervision of the county health administrator, the receptionist/clerk I performs a wide variety of clerical/receptionist functions to include all activities pertaining to clinic flow. The employee in this position is frequently expected to act independently in answering citizen inquiries, typing correspondence, scheduling appointments, use the computer and maintaining the office in good working order. This position is assigned specific duties to serve the public and assist the county health department with specialized assignments.

Duties and Responsibilities:

- Greets visitors, ascertains nature of business and notifies staff of service needed with appropriate client chart
- Inputs client information into the computer
- Prepares next day's charts for incoming appointments and prepares appointment sheet for the next days business
- Types and files correspondence, memos and reports
- Records statistics, maintains records, reports and does intake with clients for specific programs
- Answers telephone, takes and delivers messages: Treats each caller with respect and courtesy
- Treats public with respect and courtesy at all times receives payments and issues receipts
- Assists public in filling out forms and statements
- Keeps track of the numbers of clients seen in various programs and records names and numbers in the appropriate books
- Protects patients privacy and maintains confidentiality of ALL patient records and information
- Completes relevant Kansas WIC Self-Instruction modules during orientation and attends new employee training for the WIC Program
- Distributes WIC vouchers
- Makes copies of correspondence or other printed matter using copy machine
- Composes and types routine correspondence, files correspondence and other records as needed
- Demonstrated flexibility in responding to additional assignments
- Will work hours agreed upon with Administrator
- Other related duties as deemed necessary or as required

Working Conditions

- Work Environment - Daily contact in health department with clients. Subject to contact with communicable diseases.
- Mental Functions - Ability to analyze facts and to make sound judgment. Ability to listen to information and instructions and apply them to new situations. Ability to see differences in small details. Ability to make change. Ability to follow verbal directions.
  Physical Functions - Ability to bend body downward and forward by bending spine at the waist. Ability to lift at least 25# (employee must occasionally lift or move 25#). Ability to communicate ideas by means of the spoken work. Ability to hear direction. Ability to seize, hold, grasp, turn or otherwise work with hand or hands. Ability to pick, pinch or otherwise work primarily with fingers, rather that with whole hand or arm.
  Accountability - Take responsibility for collection client fees and making correct change when necessary.
- Supervision - Supervision is provided by the county health administrator. Employee does not have supervisory responsibility over subordinate personnel.

Minimum Qualifications

- Experience - Two to three years of clerical experience and bookkeeping experience is required. The employee is expected to have acquired the necessary information to perform the job proficiently within six months to one year.

- Education - High School diploma or GED required. And 2 years experience in secretarial field or vocational, technical and business school training or college, may be substituted for the required experience.
- Skills specific to the job - Ability to operate a word processor, calculator, fax and other office equipment. Must have computer skills and knowledge (familiar with Windows 95 and Word Perfect). Knowledge of modern office practices procedures and equipment MUST have the ability to work with the public and keep confidentiality in all areas of patient contact. Knowledge of business, bookkeeping, English, spelling and arithmetic. Ability to operate multi-line telephone system. Ability to make minor decisions in accordance with precedents and regulations set forth by the Department and Kansas Department of Health and Environment and to apply these to work situations. Ability to work under pressure and or frequent interruptions. Ability to set up and type a variety of accounting, statistical and financial statements, letters, special records and reports. Post incoming and outgoing mail as needed.
- Special Requirements - Maintain current CPR certification. Ability to work cooperatively with others. Must demonstrate flexibility and good judgment in dealing with individual situations. Must be willing to accept changes in work routine as the need arises. Should be able to work independently in a reliable and dependable manner. Have ability to maintain effective working relationship with other employees.

Interview Questions for Clerk/Receptionist

Name of Applicant:

Introduction of those present:

Interviewer should review County Policies/Benefits

Examples:

- Holidays
- Sick leave
- Vacation/leave accrual
- Continuing Education
- KPHA dues
- Mileage rate for private vehicle (if appropriate)
- County vehicle usage
- Health insurance
- Retirement and/or KPERS
- Pay periods, i.e., monthly, biweekly, etc.
- Longevity pay

(Provide a copy of the job description to the interviewees for review)

1. After reviewing the job description, what questions do you have regarding the responsibilities of this position?

2. Describe your past work experience and responsibilities.

3. What office machines have you had experience with and on a scale of 1-5 (5 being the highest) rate your skill level with each of them.

4. What experience have you had in the following areas?
   a. Meeting the public:

   b. Scheduling appointments:

   c. Answering the telephone:

5. What do you consider the most important aspects of these tasks?

6. What experience have you had with:
   a. Filing:

   b. Accounting:

   c. Multi-line telephones:

   d. Computers:

7. This position requires diverse skills and responsibilities. How do you prioritize your work?

8. Situation: A WIC client becomes angry at the reception desk when she cannot pick up her vouchers at an unscheduled time. How would you respond to her?

9. How do you manage conflict with co-workers?

10. What characteristics do you think you possess that world be beneficial to fulfilling this job?

11. This job requires that you be certified in CPR. Have you ever been certified in CPR and how would you feel about maintaining this skill?

Discuss salary at this time, how much the applicant expects and if negotiation is possible.

12. What other questions do you have at this time?

13. If you are offered this position, will you accept it?

14. If you are offered this position, when would you be available to begin work?

Discuss when you expect to make your decision and when the applicant will be notified whether on not they are hired.

BE SURE TO CHECK REFERENCES!

Comments:

_____ COUNTY

Performance Evaluation

_____

Employee Name

_____

Job Title

_____

Department

Merit _____ Promotion _____ End of Training Period _____

Other _____

Reason for Review

Evaluation Checklist

This evaluation is intended to be used as a communication tool between you and your employee. It is also used to measure whether the employee's performance and productivity have been sufficient to warrant a merit pay increase.

Remember that this evaluation covers a number of months. If you did not keep any written records of your employee's performance during this evaluation period, jot down any positive or negative circumstances you can recall before you complete this evaluation form. Do not base your opinion of the employee's performance on the past few days or weeks.

Check your employee's personnel file and make sure you are aware of its contents. If previous evaluations have been placed on file, review them.

If, in your opinion, your employee requires improvement in a given area, do not hesitate to check that area. This evaluation process does not necessarily penalize your employee for those answers that are checked unsatisfactory. Also remember there is nothing wrong with an employee being rated satisfactory.

After you have completed this evaluation, review it again to see if it has been filled out completely and whether it fairly represents your employee's performance and productivity during the evaluation period.

When you meet with your employee to discuss this evaluation keep the following in mind:

- Conduct the evaluation session in private
- Make sure the setting is reasonably comfortable
- Explain your reasons for any high or low marks
- Listen to your employee's comments and concerns
- Be sure to make suggestions for any improvements you feel are necessary
- Be sure the employee signs the evaluation form and acknowledges whether he or she would like a copy of the evaluation

DEFINITION OF PERFORMANCE RATINGS

N – Needs Improvement – Does not meet performance standards of the job.

S – Satisfactory - Meets performance standards of the job.

A - Above Average – Exceeds most job requirements.

INSTRUCTIONS: Carefully evaluate employee's work performance in relation to current job requirements. Please mark the performance definition that best fits your employee's performance in each category. After each category is marked, **please list your comments**.

General Factors		Comments
QUALITY – Extent to which an employee's work is accurate, thorough, and neat.	Needs Improvement _____ Satisfactory _____ Above Average _____	_____
PRODUCTIVITY – Extent to which an employee produces a significant volume of work efficiently in a specified period of time.	Needs Improvement _____ Satisfactory _____ Above Average _____	_____
JOB KNOWLEDGE – Extent of which an employee possesses the practical/technical knowledge required for the job.	Needs Improvement _____ Satisfactory _____ Above Average _____	_____
RELIABILITY – Extent to which an employee can be relied upon regarding task completion & follow up.	Needs Improvement _____ Satisfactory _____ Above Average _____	_____
AVAILABILITY – Extent to which an employee is punctual, observes prescribed work break/ meal periods and has an acceptable overall attendance record.	Needs Improvement _____ Satisfactory _____ Above Average _____	_____

INDEPENDENCE – Extent to which an employee performs work with little or no supervision.	Needs Improvement _____ Satisfactory _____ Above Average _____	
CREATIVITY – Extent to which an employee proposes ideas, finds new and better ways to do things.	Needs Improvement _____ Satisfactory _____ Above Average _____	
INITIATIVE – Extent to which an employee seeks new assignments and assumes additional duties when necessary.	Needs Improvement _____ Satisfactory _____ Above Average _____	
ADHERENCE TO POLICY - Extent to which an employee follows safety and conduct rule & other established policies.	Needs Improvement _____ Satisfactory _____ Above Average _____	
INTERPERSONAL SKILLS – Extent to which an employee is willing and demonstrates the ability to cooperate, work, and communicate with co-workers, supervisors and the public.	Needs Improvement _____ Satisfactory _____ Above Average _____	
JUDGMENT – Extent to which an employee has demonstrated proper judgment and decision making skills when necessary.	Needs Improvement _____ Satisfactory _____ Above Average _____	
OTHER – List items of particular departmental significance which warrant special comments.	Needs Improvement _____ Satisfactory _____ Above Average _____	

Comments: _____

_____

_____

_____

Complete all of the following sections:
1. Accomplishments or new abilities demonstrated since last review.

2. Specific areas of improvement needed.

Acknowledgements
I have reviewed this evaluation with the employee.

_____
Supervisor Date

I have reviewed this evaluation with my supervisor and I (agree, disagree) with this evaluation. I was also given an opportunity to obtain a copy of this evaluation.

Employee Comments:

_____

_____

_____

_____

_____
Employee Date

Current Hourly Rate _____ Recommended Hourly Rate _____

Effective Date _____

Approved _____ Date _____

FOR PAYROLL DEPARTMENT

NAME OF EMPLOYEE _____

CURRENT HOURLY RATE _____

RECOMMENDED HOURLY RATE _____

EFFECTIVE DATE _____

APPROVED BY _____

CURRENT DATE _____

Recruitment/Selection Procedures

Filing a vacancy is a serious responsibility and can make the difference between getting the job done right and not getting it done at all. Those charged with this task need to understand the hiring process, develop their skills, and stick with a sound process. Arbitrary hiring decisions are very expensive. Relying too much on feelings is dangerous. Not knowing what you are really looking for can bankrupt your budget.

The Americans with Disabilities Act requires that the essential functions must be identified before proceeding with the staffing process. These are basic job duties the employee must be able to perform with or without reasonable accommodation. An analysis of the job to be done and a clearly written position description are also prerequisites. Consider technical, supervisory, and professional skills required.

Performance expectations should also be identified prior to candidate search and then reviewed with the candidate during the interview. These include job accomplishments and such things as attendance at meetings, belonging to organizations, continuing education requirements, etc. They are later incorporated into performance evaluations of the employee.

The hiring process itself can be divided into 5 major areas:

1. Prepare to Search

- Don't automatically assume a vacancy must be filled; look at the position and evaluate alternatives to hiring.
- Look for opportunities to promote from within. It is a good way to get qualified people and boosts morale. However, someone from outside brings refreshing new ideas and skills. Determine whether your agency has a policy on internal filling of vacancies before you proceed.
- Job openings that are posted give everyone who is qualified a chance to be considered.
- Know who you are looking for; determine minimum requirements for skills, work experience and education.
- Analyze the position with the help of incumbents before developing a job description.
- Decide in advance what you expect the candidate to achieve once hired. Expectations should be clear in your mind.
- Know what you can offer in the way of compensation and benefits so that you are comfortable in explaining both.
- Plan for advertising expenditures by deciding where you will get the most for your money.
- Avoid writing in advertisements that could potentially lead to a lawsuit such as discriminatory statements. Include an equal employment statement.
- Look for creative recruiting alternatives if you are having a problem finding good people. Encourage employees to refer potential candidates; offer an incentive for successful finds.
- Agencies can be useful but review their contract closely. Be particularly aware of costs and pressure to hire. Don't forget State Employment Services.
- Prepare questions in advance of the interview, including open-ended and behavior-based questions to help you meet goals for the interview and learn more about the candidate.

2. Screening

- Sort into three stacks: meets all requirements, meets most requirements, and does not meet requirements.
- Telephone pre-screening is quite useful and cuts down on the number of face-to-face interviews required. In the telephone interviews, work from a list of prepared questions that are based upon the skills and work experience required.
- Always give the candidate the option of calling you back at a more convenient time.
- Any tests that screen out minorities as compared to other groups are illegal under EEO guidelines.
- Drug and alcohol tests may be used to screen out potential problem employees. The ADA does not protect employees or applicants who are currently engaged in illegal use of drugs or alcohol.

3. Interviewing

- Understanding that the interview best measures interpersonal skills and job knowledge, not skill level.
- Past behavior and job history are often good indicators of future success.
- Read cover letter, resume and/or application immediately before you meet with the candidate face-to-face for the first time.
- Allow 45 minutes to 1 hour for the initial interview.
- Follow an agenda and stick to your questions to avoid getting off track.
- Be on time for the interview, greet the candidate, make sure the site is comfortable and inviting, establish rapport, put candidates at ease, and never allow interruptions of any kind.
- Share your agenda and ask permission to take notes.
- Stay out of court by asking job related questions only and avoiding discriminatory statements.
- Listen for what the candidate is not saying, and don't hesitate to probe for more information if you need clarification.
- Gather information about the candidates before you invite them to question you.
- Be patient, avoid stress tactics and don't overload the candidate with more that one question at a time.
- Learn how the Americans with Disabilities Act (ADA) impacts interviewing and the correct way to interview candidates with disabilities.
- It is important to sell your organization to the candidate, but only at the end of the interviews.
- Every candidate, whether final or first interview, should be told what the next step will be.
- Leave a good impression on everyone by closing with a "thank you" in a friendly and positive manner even if you do not plan to hire the candidate.
- Document the interview but never write anything on the resume or application that could be taken as discriminatory.

4. References

- Have candidates sign a release from liability form so that references will feel more comfortable in giving information.
- Reference checks are usually conducted by phone using a similar list of questions for each of those being considered for the same position.
- You may not ask anything during the reference check that you could not legally ask of the candidate in person, including questions related to race, sex, religion, national origin, etc.
- Always check references yourself, and check on only those who are serious contenders for the job.
- Document findings as you go and use an evaluation form to help compare candidates.

5. The Final Decision

- Notify unselected candidates before announcing your selection. Let current employees who did not get the promotion know why and what they can do to have a better chance for other job openings in the future.
- Any candidate who appears too good to be true should be a sign that you should conduct an especially thorough interview and reference check before making the final decision.
- Potential is important, but don't hire someone solely on what he or she may someday be able to accomplish.
- Expect post-offer queries and counter-offers and be prepared for them.
- Make a job offer as soon as possible in order to avoid losing a good candidate.

Salaries

Salaries, benefits, and expectations should all be defined in writing before the search begins and then discussed with final candidates prior to the offer. Ask candidates about salary history or requirements during the first interview or telephone screen. These can be reviewed before the final decision is made. If you are unable to meet salary expectations, decide whether you may offer perks. Examples of these include tuition reimbursement, company paid dues for association membership, compensatory time off, employment contract, sign-on bonus, and relocation costs.

Points to be considered when defining compensation and benefits:

1. Know what your competitors pay.
2. Consider the cost of living in your area.
3. Understand supply and demand.
4. Think about ways to compensate other than money.
5. Check recent salary survey (or conduct one if necessary) to determine the going rate in your part of the country or community.
6. Determine whether you are willing to pay extra for more years of experience that you originally wanted for an exceptionally well-qualified candidate.

The salary schedule for all employees of the agency should be defined in writing and should include pay dates, method of disbursement (including mandatory deposits by the agency), step increments and criteria, holiday pay, overtime, and time verification requirements.

References

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Information Management

Patient Integrated Record

In most health care delivery systems, information pertinent to a client's problems is scattered throughout the record or scattered throughout many unrelated records in unrelated offices. Patients are left to relay important information from one agency to another or from one provider to another. If providers collaborated in care, this information could be stored in one common record.

What is a health record?
A systematic, logical format for storing data, which reflects the analytical approach, involved in diagnosing and evaluating care and the interpersonal process involved in patient care delivery. Patient records serve the provider in three ways:

- Document that a transaction has occurred between patient and provider.
- Document the process of patient care, the decision-making that has occurred between provider and client. They are an account of the assessment process.
- Allow the provider to demonstrate that the process of care is dynamic.

What is the purpose of Health records?
Health Records:

- Are the diary of what has been done and a program for what needs to be done. They not only record the care but also help to ensure it.
- Serve as a communication tool between health members and administration.
- Document cared and therapy.
- Serve as a basis for quality care.
- Serve as legal documents for both provider and client.
- Is a starting point for collecting patient facts.

What are the essential components of the record?

A. Data Base
   1. The object of the database is to store pertinent information but also to allow the reader to scan the record briefly and quickly obtain a profile of the patient.

B. Problem list
   1. The sheet in the front of the chart containing a numbered, titled, and dated list of patient problems.
   2. The problem is defined as some aspect of the patient, which requires further attention, observation, diagnosis, management, or education.

C. Care Plan
   1. The care plan consists of an initial plan for dealing with a specific problem and a systematic update of the plan.
   2. A hallmark of quality care plans is that they are dynamic.

D. Progress notes or flow sheets
   1. These are concise, accurate accounts of patient progress. Flow charts serve to organize the management of patient care into easily identifiable criteria. Progress is charted at a quick glance. Progress notes validate the plan of care.

Evaluating the Patient Record

1. Does the patient receive more than one type of health delivery service?
2. Does the record document a complete list of services currently being provided?
3. Does the record document a complete list of problems for which the patient is currently being treated?
4. Does the record document a complete list of providers currently involved in patient care?
5. Does the record document a current plan of care?
6. Is the plan of care dated? Has it been updated?
7. Does the plan of care document integration of care?
8. Do other providers in the service are participate in the plan of care?
9. Is the integrated plan updated?
10. Are specific treatment modalities noted?
11. Does our agency have policies concerning patient records?
12. Does the agency identify the person responsible for integration of service?
13. Does the agency require updating the plan of care or problem list at specified intervals?

Medical Records Management

Guidelines for Client Record Retention

Each local department should have written guidelines for client record retention, which have been concurred with standards by the Kansas Historical Society and signed by the board, county attorney, and county health administrator.

Clinical records should be maintained ten years following closure for adults and one year after reaching age of majority (age 18 in Kansas), whichever is longer. This covers the Statute of Limitations provision for filing suits in relation to negligence (K.S.A. 60-513(a)(7)).

Home Health Agency fiscal records should be kept for five years. In the event of closure, records should be retained for five years following acceptance of the final cost report.

Immunization card files should be maintained for 20 years.

Informed consent slips should be kept indefinitely.

Communicable disease and venereal disease records do not need to be retained longer than two years if no treatment is involved. If client information is needed on a person with venereal disease beyond that point, it would be obtained from the Kansas Department of Health and Environment registry. The treatment record should be maintained for five years.

Employee time report cards must be retained at least three fiscal years and then may be destroyed.

Childcare licensing files have no maintenance requirement at the local level. The official childcare licensing files are in the Child Care Licensing Section of the Kansas Department of Health and Environment. Federal auditors can be referred to the Kansas Department of Health and Environment office where the source document can be reviewed.

The Kansas Historical Society http://www.kshs.org has statutory responsibility for determining length of retention and record disposition. The guidelines are available by request. Statutes that refer specifically to the issue of record retention are: K.S.A. 45-401 and K.S.A. 45-404.

Impact of HIPAA on Local Health Department Operations

The Health Insurance Portability and Accountability Act of 1996 was seen as major legislative reform of various aspects of the health insurance of all Americans. Effective April 14, 2003, all health care providers meeting certain criteria were required to implement changes in practice relative to the collection, retention, and sharing of patient information. This legislation also changed the way billing for services was performed, effective October 16, 2002. Most health departments in Kansas requested, and received, a one-year extension of this implementation date, making that portion of the Act that applied to electronic billing effective October 16, 2003.

The Kansas Association of Local Health Departments, with the support of a grant from the Kansas Health Institute, reviewed pertinent sections of the Act. Technical assistance sessions were held through 2002 and early 2003, with user-ready materials provided to each health department on CD-ROM. All health departments in Kansas have designated certain individuals to serve in oversight roles for HIPAA implementation. As the health department becomes more familiar with the impact HIPAA has on day-to-day operations, these individuals should review policies and procedures in order to ensure continued compliance with this important legislation.

Transfer of Records and Release of Information

The client must sign an authorization for release of information before any information regarding the client can be transferred to another agency or provider. When the client requests a transfer of the record, the public health nurse should prepare a summary of the record or make a copy of the record to be sent to the other agency or provider. The original record must stay within the health agency. The exception to this would be in honoring an interagency contact providing for the official transfer of original records such as the KAN-Be-Healthy agreement with the Department of Social and Rehabilitation Services. Another exception is when a law requires the exchange of information such as with suspected cases of child abuse.

In the case of legal investigation, client information cannot be released without the client's written authorization or a court subpoena for the record. The county attorney is available for consultation regarding legal matters. Agency policy for patient access and transfer of records should include:

1. Person who is identified as "keeper of records,"
2. Defined content of the record to be transferred,
3. Time and process for viewing records,
4. Assurance that no records leave agency,
5. Cost for record copies, and
6. HIPAA privacy regulations

Freedom of Information Act

On occasion, a health department will encounter someone who wants certain medical or disease intervention records and who cites the Freedom Of Information Act (F.O.I.A) as the basis for his or her demand. Such demands are groundless, as affirmed by the United Stated Supreme Court in the case of Forsham vs. Harris, Sup. Ct. No. 78-1118, 3/31/80. The F.O.I.A. is a federal law, which has limited application. State and local government agencies are not affected by it. In Forsham vs. Harris, the court also held that the F.O.I.A. does not require the federal government to obtain or release records held by a grantee. Specifically, the opinion of the court states:

"Federal participation in the generation of data by means of a grant from H.H.S. does not make the organization a federal 'agency' within the terms of the Act. Nor does this federal funding in combination with a federal right of access render the data 'agency records' of H.H.S. which is the federal 'agency' under the terms of the Act."

Confidentiality

Health care personnel are to regard as confidential all client information in order to limit the disclosure of personal or sensitive data. The American Nurses Association's Code of Ethics directs the nurse to "safeguard the client's right to privacy by judiciously protecting information of a confidential matter."

Confidentiality is recognized in our society as a basic human right and its purpose is to encourage people to seek help in a timely manner. The Kansas Statutes states that "information should not be disclosed in such a manner that reveals the identity of the individual without the individual's consent in writing." Disclosure of confidential information without the individual's written consent abridges both legal and ethical codes.

Kansas Open Record Act

The purpose of the Kansas Open Records Act (KORA) is to make government accessible to the citizenry. It requires that public records be open for inspection. K.S.A. 45-216(a). KORA does not require government agencies to do research or to create records. It should not be confused with the Federal Freedom of Information Act (this section).

The law requires that public records shall be open to inspection upon request by any person. K.S.A. 45-218.

1. Virtually any record in the possession of a public agency is subject to the law. K.S.A.45-217(f)(1).

2. There is an exception, however, for records, which are owned by a private person or entity and are not related to functions, activities, programs or operations funded by public funds. K.S.A. 45-217(f)(2).

3. Public Agency means the state or any political or taxing subdivision of the state, or any entity supported by public finance.

Exceptions to KORA fall into two categories, records that may be withheld, and records, which must be withheld.

1. Certain records are protected by federal or state statute. Access to these records must be denied. K.S.A. 45-221(a). There are several state statutes providing that certain records are confidential. Note especially K.S.A. 65-118 infectious disease information, and K.S.A. 65-6002 HIV information. Note, however, new statute requiring notification of health care provider of victim of sex crime of HIV status of perpetrator. 1993 Sess. Law. Ch 242.

2. Many statutes providing for confidentiality also have exceptions to the confidentiality requirements. In these cases the material must be made available if the exceptions are met.

Privileged information must also be withheld. K.S.A. 45-221(a)(2).

1. Physician/patient communication is privileged. K.S.A. 60-427.

2. Attorney/client communication is privileged. K.S.A. 60-426.

3. Communication with a pharmacist and records of prescriptions filled by pharmacist are given the same status as physician/patient communications. K.S.A. 65-1654.

There is an extensive list of other documents, which may be withheld. K.S.A. 45-221. Better practice is to deny access to these documents.

It is a misdemeanor to give lists of names and addresses for commercial purposes. K.S.A. 21-3914. The best practice is to make anyone who requests a list of names and addresses to sign an affidavit.

Compliance with KORA:

1. Access to public records must be afforded during regular business hours or at other time specified, but public records may not be removed. K.S.A. 45-218(a).

2. The agency may demand advance notice, but may not require that the notice be in writing. Access must be afforded within three working days. K.S.A. 45-218(d).

3. If an agency refuses to allow access to the record, it must do so in writing, and explain the reason for the refusal. K.S.A. 45-218(d). The agency may refuse for the reasons discussed above, or if a request "places an unreasonable burden in producing public records of if the custodian has reason to believe that repeated requests are intended to disrupt other essential functions of the public agency." K.S.A. 45-218(e).

The agency must permit copying of public records, but need not provide copies of radio or recording tapes or discs, video tapes or films, pictures, slides, graphics, illustrations or similar audio or visual material, unless those materials were shown or played at a public meeting. K.S.A. 45-219.

1. May charge a reasonable fee.

2. May require a written request.

3. May require written certification that the records will not be used for an improper purpose.

References

Stottlemire, M.G. (1993, September). Kansas Open Records Law and Confidentiality. Paper presented at the Kansas Public Health Association Annual Conference, Lawrence, KS.

Admission, Readmission, and Discharge Service Guidelines

A. Admission

1. General statement

A client should be admitted when she or he has received or is anticipated to receive a significant amount of service in any setting such as home, office, or clinic. A significant amount of service can be two or more contacts after a screening or if, in the judgment of the provider, a substantial service is given in a single contact. If different services are being provided to the same individual, that client may be admitted to more than one program (e.g., WIC and Well Child). A department may wish to establish a policy regarding use of family versus individual service folders.

2. Admission Examples

The following are examples to assist you in establishing policies within your department. It is anticipated that you will be able to take these and apply them to all services you deliver.

a. Hypertension clinic clients

If it is anticipated that the client will be or is returning, the client should be admitted.

Those clients seen briefly in a screening clinic should be admitted if there is an identified problem and further contact is needed.

Those clients seen briefly for screening and not in need of follow-up should not be admitted.

b. Immunization clients

Clients receiving a series of immunizations should be admitted and retained in service until boosters are completed or the service has been discontinued.

Clients receiving only a one-time-a-year influenza immunization should not be admitted. However, the signed informed consent form should be retained.

c. TB skin testing clients

Admit client when there is a positive reaction and referral, or when follow-up or medication monitoring will be done. Admit contacts of an active case until retesting and/or medication is completed.

Do not admit those receiving only a skin test.

d. Pregnancy testing and counseling

This is considered a significant service and the client should be admitted.

e. Clients receiving medication

All clients receiving medication dispensed or administered by health department personnel must be admitted to services.

f. All clients attending other regular clinics such as KAN-Be-Healthy, W.C.C., Family Planning, S.T.D., M. & I., W.I.C., etc., must be admitted.

g. All clients receiving home visits and periodic office visits must be admitted.

B. Readmission

1. General statement

A client should be readmitted when she or he has previously been admitted and discharged from a program, and the service for that program is resumed.

The criteria for readmission is the same as for admission, except a client can be readmitted when first seen for services rather that waiting for a second or third visit as described in some of the admission examples.

C. Discharge

1. General statement

A client should be discharged from a program when the service is discontinued and it is not anticipated to be resumed. A client can be discharged from one program and be retained in another. Some reasons for discontinuing a service are:

a. The service is no longer needed.

b. The client is no longer eligible.

c. The client no longer wants the service.

d. The service is no longer available.

e. The client moves from the service area.

f. The client transfers to another service.

g. The client is deceased.

Discharge should be made as soon as it is known that the service is discontinued.

All client records should be reviewed annually to determine date of last encounter and current status of service.

Each nurse should keep a record of her caseload to facilitate follow-up. When the nurse attempts two or more contacts and is unable to locate the client, these attempts should be documented in the record and the client should be discharged. (This would depend on agency policy).

Departments should maintain a master index file to reflect the status of all clients' records. This can be done manually or by computer. All records should contain identifying data (such as names, addresses, phone numbers, and birth dates).

Policies and Procedures

Policies and procedures need to be relevant to the specific goals or purposes of the agency. They should be definite and stable, but flexible enough to be adjusted to meet any fundamental change. They should be stated in a simple, succinct manner so that they can be understood and followed. These policies and procedures form the basis for quality assurance.

Strict adherence to policies and procedures in practice is very important and should include no exceptions. To accomplish this, employee participation in their development is essential. Policies and procedures encourage an agency to conserve its energies and resources by directing them toward established goals. In addition, they provide the necessary framework and organizational stability to confront and resolve problems. They provide the employees with established guidelines and thus support the effectiveness of their decision-making capabilities. They promote and encourage individual accountability and eliminate inconsistencies.

Policies are general statements about the overall program operation. They provide basic direction for maintenance of the program and are concerned with administrative as well as clinical circumstances. Policies are typically statements about the agency's assumptions and philosophy. (Example: All personnel involved in providing patient care in the clinic will be CPR-certified on an annual basis.)

Procedures provide detailed, step-by-step instructions for performing specific procedures in the Agency. Procedures are process-oriented and direct personnel in carrying out laboratory tests, counseling sessions, release of medical records, and any other task for which staff members are responsible. (Example: The blood pressure is measured by placing the cuff of the instrument around the patient's arm approximately two inches above the antecubital space….)

Standing orders are instructions, written and signed by physicians, to authorize or delegate medical actions in response to specific clinical care situations. They are explicit instructions about treatment which are communicated to a licensed person other that a physician (usually an ARNP or a RN). In the ambulatory setting, standing orders are generally related to prescription medications. They are extremely specific, deal with one single problem, and do not address assessment or diagnosis. Standing orders may be part of the clinical directives, but they must be reviewed, approved and signed annually by a physician, usually the Medical Consultant.

Protocols are written agreements between health care professionals, and generally apply to the judgment guidelines for the practice of advanced practice nursing. They are more precise than guidelines and allow for varying degrees of independent action. They attempt to standardize diagnostic and management strategies in an explicit and concise manner. (Example: Physicians and nurses who work together to establish or delineate areas of dependent, independent, and interdependent function; consistent, standardized data base; criteria for audit of care and performance; and assurance of thoroughness).

Types of Policies and Procedures

Organizational Policies and Procedures outline the implementation of management and administrative functions throughout the agency, including the establishment of clear lines of responsibility and accountability within each department and between departments.

Contractual Policies and Procedures outline the delineation of the credentialing and clinical privileges of physicians, nurse practitioners, and other health care providers. They can also outline effective management, safety, and quality controls for services from outside resources.

Rights and Responsibilities of Clients Policies and Procedures identify the basic rights of all human beings for independence of expression, decision, and action and concern for personal dignity and human relationships. It becomes the responsibility of the health professionals to assure that these rights are preserved for the clients.

Health Record Policies and Procedures ensure that an agency maintain confidential medical records that are documented accurately and in a timely manner. The records are readily accessible to appropriate personnel and permit prompt retrieval of information. Health records are maintained for each client receiving care and support the diagnosis and document the course and results of treatment accurately.

Financial Management and Accountability Policies and Procedures include all fiscal issues involved with the operations of a health agency, as well as an itemized and detailed explanation of fees for services rendered to a client.

Quality of Care Policies and Procedures demonstrate a consistent endeavor to deliver client care that is optimal within available resources and consistent with stated goals. They also demonstrate a planned and systematic process for monitoring and evaluating the quality and appropriateness of client care and for resolving identified problems. To assure quality of care, a mechanism for quarterly record review is established.

Emergency Policies and Procedures specify the scope and conduct of client care to be provided in an emergency.

Infection Control Policy and Procedures outline an effective program for the surveillance, prevention and control of infection.

Pharmaceutical Policies and Procedures specify the administration of medications by nurses and the prescriptive authorization for nurse practitioners.

Facilities Policies and Procedures specify that the areas in which clients receive treatment are designed, constructed, equipped and maintained in a manner that is designed to provide for the physical safety of clients, personnel and visitors.

Maintaining and Revising Policies and Procedures

The Policies and Procedures should be reviewed on an annual basis, or more frequently if indicated, by the administrative staff of the agency. All policies and procedures need to authenticate by date and signature and title of the director/administrator. In addition, periodic reviews should be done by the professional staff. Another phase can take place during the orientation process of new employees. They can be requested to note any questions or concerns for which there is no policy or procedure and for which they have to depend on word-of-mouth information.

A manual should be constructed so that policies and procedures can be added or removed when appropriate. A simple loose-leaf notebook can be used. The manual should be divided into sections and subsections with their own pagination for easier use and revisions. A Policy and Procedure Manual is only useful when it is accessible. All staff should know the location of the Manual. Participation of all staff in the formation and revisions of policies and procedures is essential. When employees are involved, there will be a stronger commitment for success.

Clinical Protocols

Clinical protocols generally refer to guidelines between advanced practice nurses and the consulting physician. Written practice protocols assure consistent practice of high quality by specifying what history must be obtained, what physical findings examined, what laboratory tests preformed and what plan implemented. They clarify the scope of nursing practice and the consultation arrangement by stating the circumstances under which the nurse should consult a physician. Written protocols are required for the prescriptive authority of nurse practitioners.

The clinical staff may decide to write its own practice protocols, either as adjuncts to a published text or as the sole guide for the practice. Thus the protocols developed will be appropriate for the particular patient population, clinical setting, and expertise of the staff. Staff can therefore give the best care of which they are capable, without artificial limitations, the protocols need to be updated whenever new knowledge becomes available, and they should be reviewed at least annually to assure accuracy.

A new protocol is started whenever a nurse determines that one is needed. Usually the nurse who noted the need or one with particular expertise in a given area, agrees to write the initial draft. A search of the current literature starts the process. Next protocol is written. One format that may be used is:

- Definition
- Subjective
- Objective
- Labs
- Assessment
- Consultation/Referral
- Plan
    - Diagnosis
    - Treatment
    - Patient education
    - Follow-up
- References

The writer submits the initial draft of the protocol to his/her peers for critique. The colleagues give the writer input and consensus is reached about any disputed areas using the literature. The writer modifies the protocol, which is then formally adopted when it is signed by the Clinical Director and the consulting physician. All staff members review protocols annually, modify them as needed, and then the director and physician re-sign the protocols.

Medical Record for Employees

The health and safety of public employees is important to personnel managers because these issues have become a significant concern of the employee-employer relationship and because there is increasing evidence that healthier employees are more productive and happier than unhealthy ones. Employees have the right to constitutional protections against violations of privacy in their personal lives. Yet management must create conditions, which support the maintenance and rehabilitation of employees as human resources.

Pre-employment physicals are routinely used to exclude applicants whose medical history places them at risk. Requirements for the physical exam should be listed in employee policies.

Additionally policies may be established to have physical exams or certain health screenings done annually or every two or three years. Policy should state how often, who may do the exam, on what form or what is to be included, and where that form is to be kept. Documentation of required immunizations (as stated in policy) should be included. TD, MMR, documentation of polio series (OPV contraindicated in persons over age 18), Hepatitis B, and TB skin test are usually required. Most local health departments will provide the immunizations free to their employees and if so this should be stated.

Medical Record for Client

Each agency should establish a confidential medical record for every client receiving services. This record includes any necessary permission for services, personal data, health/medical history, problem list, physical exam results, appropriate laboratory results, treatment and or education provided, and scheduled revisits.

In addition to the common core elements of all records, applicable program forms or records should be included as well. Examples of these are provided in program manuals.

References

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Kansas Department of Health & Environment. (1990). Guidelines for Completing Performance Evaluations.

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Administrative Forms Defined

Contract:
An agreement between two or more persons/parties, which creates an enforceable obligation to do or not to do a particular thing. Essential components of a contract include: 1) competent parties, i.e., of legal age and legally competent, 2) a legal consideration, 3) mutuality of agreement, and 4) mutuality of obligation. The writing contains the agreement of parties, with the terms and conditions, and which services as proof of the obligation. Consideration means that each party offers something of value to the contract. A contract is established for a specific amount of time or it has an automatic expiration or renewal clause that stated the contract is in force unless either party gives notice of termination, i.e., 30 days.

Incident Report:
A mechanism, established by an agency, by which staff is to inform the agency and its staff of any unusual occurrence/injury to clients/families for which the agency might be held legally responsible for damages.

Injury Report:
A mechanism, established by an agency, by which staff is to report injury or possible injury to a member of the staff for the purpose of protecting the agency and staff member in regards to Workers Compensation.

Interlocal Agreement:
An understanding or intention between two or more parties, usually local governmental agencies that is enforceable and binding, with respect to their rights and duties.

Memorandum of Understanding:
An informal instrument or briefly written statement outlining the terms of an agreement between two or more parties under which they will operate when the law is not specific. Its purpose is to guide the agencies and staff and is not binding by law. An example might be an agreement between SRS and the LHDs concerning the responsibilities assumed in the investigation of allegations of child abuse.

References

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Organizational Management (QA)

Health Department Facilities

Several things are to be considered when choosing a location for a local health department facility. Although often the "ideal" facility is not available, negotiations and modifications may result in an adequate worksite.

High priority needs:

Handicapped accessibility for entrance and restroom facilities.
Hot and cold running water and working drains.
Adequate heating and lighting.
Adequate parking for clients.
Private areas for exams, interviews, and education.
Refrigerator with alarm system for storing biologicals.
A filing system that can be locked.
A working telephone.
Modern professional equipment in working order with which to conduct examinations and take measurements.

Other Needs:

Computer with modem, internet access, and printer.
Method of sending and receiving FAX messages.
Quiet room for audiometric testing.
Spacious waiting room with educational items of interest.

OSHA and Bloodborne Pathogens

In 1970, the U.S. Congress established the Occupational Safety and Health Administration as a division of the Department of Labor. Its purpose was simply to assure a safe and healthy working environment. In general, OSHA regulations cover employees in the 50 state, the District of Columbia, Puerto Rico, the Virgin Islands and other territories under U.S. jurisdictions.

There are 10 regional offices of OSHA that direct the activities within the states assigned to each region. In addition, individual states may petition to develop their own state OSHA programs. Such programs must be at least as effective as the federal OSHA program and are more stringent in some cases. In Kansas, the private sector is regulated by federal OSHA guidelines while the public sector is regulated by Kansas Department of Human Resources (KDHR), Industrial Safety and Health section.

Kansas Statutes Annotated (K.S.A.) 44-636 gives KDHR the authority to protect public employees in the workplace including those employees by state, city, county, region, and schools. This section provides advice to Kansas businesses concerning workplace safety and health, inspects and advises state government, local government and schools concerning workplace safety and health, offers education and training programs for Kansas businesses and workers, inspects for occupational health hazards, hazardous chemicals and maps underground mines. It is this agency that regulates the bloodborne pathogen standard for public and governmental agencies in Kansas and has stated that it will use the federal standard for routine public inspection.

The OSHA standard involving bloodborne pathogens can basically be divided into six broad categories collectively referred to as the **Exposure Control Plan**. These categories include (1) exposure determination, (2) universal precautions, (3) engineering and work practice controls, (4) hepatitis B prophylaxis, (5) training and education, and (6) record keeping. All employers having an employee(s) with occupational exposure as defined in the plan are required to establish a written Exposure Control Plan addressing each of these categories. A model (generic) bloodborne pathogens exposure control plan is available for U.S. Dept. of Labor-OSHA offices in Wichita and Mission, KS.

References

Code of Federal Regulations, Title 29, Subpart Z, 1910.1030 Bloodborne Pathogens.

Places of Business; Inspection; Safety and Protection of Employees; Order; Notice and Hearing; Penalty. 3A Kan. Stat. Ann. §§ 44-636 (1986).

Bloodborne Infections: A Practical Guide to OSHA Compliance. (1992), Johnson & Johnson Medical, Inc. Arlington, Texas Author.

Bloodborne Pathogens Final Standard: Summary of Key Provisions

PURPOSE: Limits occupational exposure to blood and other potentially infectious materials since any exposure could result in transmission of bloodborne pathogens, which could lead to disease or death.

SCOPE: Covers all employees who could be "reasonably anticipates" as the result of performing their job duties to face contact with blood and other potentially infectious materials. OSHA has not attempted to list all occupations where exposures could occur. "Good Samaritan" acts such as assisting a co-worker with a nosebleed would not be considered occupational exposure.

Infectious material include semen, vaginal secretions, cerebrospinal fluid, synovial fluid, pleural fluid, pericardial fluid, peritoneal fluid, amniotic fluid, saliva in dental procedures, any body fluid visibly contaminated with blood and all body fluids in situations where it is difficult or impossible to differentiate between body fluids. They also include any unfixed tissue or organ other than intact skin from a human (living or dead) and human immunodeficiency virus (HIV)-containing cell or tissue cultures, organ cultures and HIV or hepatitis B (HBV)-containing culture medium or other solutions as well as blood, organs or other tissues from experimental animals infected with HIV of HBV.

Exposure Control Plan: Requires employers to identify, in writing, tasks and procedures as well as job classifications where occupational exposure to blood occurs—without regard to personal protective clothing and equipment. It must also set for the schedule for implementing other provisions of the standard and specify the procedure for evaluating circumstances surrounding exposure incidents. The plan must be accessible to employees and available to OSHA. Employers must review and update it at least annually—more often if necessary to accommodate workplace changes.

Methods of Compliance: Mandates universal precautions, (treating body fluids/material as if infectious) emphasizing engineering and work practice controls. The standards stress hand washing and requires employers to provide facilities and ensure that employees use them following exposure to blood. It sets forth procedures to minimize needle sticks, minimize splashing and spraying of blood, ensure appropriate packaging of specimens and regulated wastes and decontaminate equipment or label it as contaminated before shopping to servicing facilities.

Employers must provide, at no cost, and require employees to use appropriate personal protective equipment such as gloves, gowns, masks, mouthpieces and resuscitation bags and must clean, repair and replace these when necessary. Gloves are not necessarily required for routine phlebotomies in volunteer blood donation centers but must be made available to employees who want them.

The standard requires a written schedule for cleaning, identifying the method of decontamination to be used, in addition to cleaning following contact with blood or other potentially infectious materials. It specifies methods for disposing of contaminated sharps and sets forth standards for containers for these items and other regulated waste. Further, the standard includes provisions for handling contaminated laundry to minimize exposures.

HIV and HBV Research Laboratories and Production Facilities: Calls for these facilities to follow standard microbiological practices and specifies additional practices intended to minimize exposures of employees working with concentrated viruses and reduce the risk of accidental exposure for other employees at the facility. These facilities must include required containment equipment and an autoclave for decontamination of regulated waste and must be constructed to limit risks and enable easy clean up. Additional training and experience requirements apply to workers in these facilities.

Hepatitis B Vaccination: Requires vaccinations to be made available to all employees who have occupational exposure to blood within 10 working days of assignment, at no cost, at a reasonable time and place, under the supervision of licensed physician/licensed healthcare professional and according to the latest recommendations of the U.S. Public Health Service (USPHS). Prescreening may not be required as a condition of receiving the vaccine. Employees must sign a declination form if they choose not to be vaccinated, but may later opt to receive the vaccine at no cost to the employee. Should booster doses later be recommended by the USPHS, employees must be offered them.

Post-Exposure Evaluating and Follow-Up: Specifies procedures to be made available to all employees who have had an exposure incident

plus any laboratory tests must be conducted by and accredited laboratory at no cost to the employee. Follow-up must include a confidential medical evaluation documenting the circumstances of exposure, identifying and testing the source individual if feasible, testing the exposed employee's blood if he/she consents, post-exposure prophylaxis, counseling and evaluation of reported illnesses. Healthcare professionals must be provided specified information to facilitate the evaluation and their written opinion on the need for hepatitis B vaccination following the exposure. Information such as the employee's ability to receive the hepatitis B vaccine must be supplied to the employer. All diagnoses must remain confidential.

Hazard Communication: Requires warning labels including the orange or orange-red biohazard symbol affixed to containers of regulated waste, refrigerators and freezers and other containers, which are used to store or transport blood or other potentially infectious materials. Red tags or containers may be used instead of labeling. When a facility uses universal precautions in its handling of all specimens, labeling is not required within the facility. Likewise, when all laundry is handled with universal precautions, the laundry need not be labeled. Blood that has been tested and found free of HIV or HB, and released for clinical use, and regulated waste which has been decontaminated, need not be labeled. Signs must be used to identify restricted areas in HIV and HB research laboratories and production facilities.

Information and Training: Mandates training within 90 days of effective date, initially upon assignment and annually—employees who have received appropriate training within the past year need only receive additional training in items not previously covered.

Training must include making accessible a copy of the regulatory text of the standard and explanation of its contents, general discussion on bloodborne diseases and their transmission, exposure controls plan, engineering and work practice controls, personal protective equipment, hepatitis B vaccine, response to emergencies involving blood, how to handle exposure incidents, the post-exposure evaluation and follow-up program, signs/labels/color-coding. There must be opportunity for questions and answers, and the trainer must be knowledgeable in the subject matter. Laboratory and production facility workers must receive additional specialized initial training.

Recording keeping: Calls for medical records to be kept for each employee with occupational exposure for the duration of employment plus 30 years, must be confidential and must include name and social security number; hepatitis B vaccination status (including dates); results of any examinations, medical testing and follow-up procedures; a copy of the health care professional's written opinion; and a copy of information provided to the health care professional. Training records must be maintained for three years and must include dates, contents of the training program or a summary, trainer's name and qualifications, names and job titles of all persons attending the sessions. Medical records must be made available to the subject employee, anyone with written consent of the employee, OSHA and NIOSH they are not available to the employer. Disposal of records must be in accord with OSHA's standard covering access to records.

Dates: Effective date: March 6, 1992. Exposure control plan: May 5, 1992. Information and training requirements and Record keeping: June 4, 1992. And the following other provisions take effect on July 6, 1992: engineering and work practice controls, personal protective equipment, housekeeping, special provisions covering HIV and HB research laboratories and production facilities, hepatitis B vaccination and post-exposure evaluation and follow-up and labels and signs.

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Employees' Right to Know - Hazard Communications Standard

The Hazard Communications Standard (HCS) is published in the Federal Register 29 CFR 1910.1200. It is enforced by OSHA and pre-empts all state and local laws except in state with OSHA-approved state programs. In Kansas, it is referenced by OSHA for private employees and by Kansas Department of Human Resources for employees of governmental agencies. (See Appendix C: Selected Resources.)

The HCS is base on the concept that employees have both a need and a right to know the hazards and the identities of the chemicals they are exposed to when working. They also need to know what protective measures are available to prevent adverse effects from occurring. This program ensures that all employers receive the information they need to inform and train their employees properly and to design and put in place employee protection programs. Employees can thus participate in, and support, the protective measures in place at their workplaces. By understanding the hazards involved, employees can take steps to protect themselves, thus preventing the occurrence of adverse effects caused by the use of chemicals in the workplace.

The HCS covers both physical hazards (such as flammability or the potential for explosions), and health hazards (including both acute and chronic effects). By making information available to employees about these hazards, and recommended precautions for safe use, proper implementation of the KCS will result in a reduction of illnesses and injuries caused by chemicals.

The HCS establishes uniform requirements to evaluate all chemicals produced, imported into, or used in the United States and required that the information be transmitted to all affected employers and exposed employees. Such information is conveyed by means of labels on containers and material safety data sheets (MSDS's).

All workplaces where employees are exposed to hazardous chemicals must have a written plan that describes how the standard will be implemented in that facility. The written plan must list the chemicals present at the site, indicate who is responsible for the various aspects of the program in that facility and where written materials will be made available to employees. It must describe how the requirements for labels and other forms of warning, material safety data sheets, and employee information and training are going to be met in the facility.

More information on this and other federal standards can be found by accessing OSHA's web site at www.osha.gov from which can be downloaded the entire standards, or accessing OSHA fact sheets or by using various search engines using the terms "employees' right to know" or "Hazard Communication Program." One such sample program outline can be seen by accessing the web site at www.pp.okstate.edu/ehs/TRAINING/Morris2.htm from Oklahoma State University. Their sample program lists the goals of the program, and its four components: 1) material safety data sheets, 2) the labeling and marking system, 3) employee training sessions, and 4) the written plan.

References:

Federal Register 29 CFR 1910.1200.

U.S. Department of Labor Program Highlights: Fact Sheet No. 93-26. Hazard Communications Standard.

Disaster Management/Emergency Response

According to K.S.A. 48-904, disaster may be defined as the "occurrence of imminent threat of widespread or severe damage, injury or loss of life or property resulting from any natural or manmade cause, including, but not limited to, fire, flood, earthquake, wind, storm, epidemics, air contamination, blight, drought, infestation, explosion, riot or hostile military or paramilitary action."

Every agency offering public health services should be a part of a specific written disaster plan with clearly identified procedures. In Kansas, the statute authority (K.S.A. 48-904 et seq) for a "state disaster emergency plan" lies within the "Division of Emergency Management" led by the adjutant general under the direction of the governor of the state. This division cooperates with similar federal agencies, those in other states, and in Kansas with city, county, regional, and intrajurisdictional disaster agencies. It has authority to require and direct the cooperation and assistance of state and local governmental agencies and officials. Immunity from liability for workers including volunteers in time of declared disaster is explained in K.S.A. 48-915. Authority for declaring and rescinding a state of disaster emergency in Kansas lies with the governor.

According to K.S.A. 48-929, each county within the state "shall establish and maintain a disaster agency … or shall participate in an intrajurisdictional arrangement for such purposes…" Thus county, city, and other jurisdictions should in turn have their own written disaster plans. All employees should be aware of the plan and at least know their expected duties. A call list should be in place so that the proper information reaches all employees. This list should include or interface with other health care personnel in the area to maximize skills and avoid duplication. In the case of the local health department, provision of continued service to some existing caseloads may be necessary because many public health clients are vulnerable or at risk populations.

Suggestions for inclusion in agency policy:

- Inclusive, up to date call list (telephone tree) to insure prompt activation of plan.
- Central place for employees to report in person or by phone for assignment.
- Identification badges or other readily visible ID for all personnel.
- Persons designated to monitor emergency frequency radio broadcasts and other sources for instructions to disaster service workers.
- Guideline to address service priorities. The level and priority of services should be determined relative to the nature and scope of the disaster.
- Person with authority to declare a public health emergency and to supervise implementation of the Public Health Disaster Plan. (Usually the Health Officer).

The Role of the PHN in Disaster Management

The role of the public health nurse may vary according to the nature of any disaster, but it is certain that the unique qualifications of the PHN allow ready adaptability to community's needs. Local PHNs should be prepared to function effectively during a disaster and may be most effective where their knowledge of the local community is essential. The PHN can be expected to exercise leadership and judgment in assessing clients for priority of care, treatment of the sick and injured, use of supplies and equipment, utilization of nursing personnel, and assisting the community in aggregate and individual living situations.

Timely and accurate communication with staff, other workers, coordinators, the press, and the public is often a joint role of the PHN and Health Officer. Dissemination of accurate health related information with regular updates on the progress and problems of disaster response is a vital task.

Responsibilities of Key Health Department Staff:

The Public Health Nursing Authority

- Assists the Health Officer in implementing the Public Health Disaster Plan and carries out other duties as assigned by the Health Officer.
- Provides training, leadership and direction for PHN disaster response.
- Determines staff capacity to function.
- Mobilizes available field staff and assigns duties.
- Provides staff with information regarding the nature and extent of the emergency.
- Provides inter-agency liaison and coordination of resources.
- Participates in planning for delivery of health care to individuals and groups whose sheltering/medical needs exceed the scope of service of relief agencies.
- Provides technical expertise/consultation on specific populations and program issues.
- Complies and analyzes data from field staff.
- Facilitates communication and reviews documentation.
- Determines location and capacity of designated shelter sites and of non-official shelter living sites.
- Provides consultation to health care personnel in shelters regarding health assessments and referrals.
- Monitors to prevent or control the spread of communicable disease in the community.
- Assists others in establishing priority for care and evaluates nursing care plans for large numbers of sick and injured in the surviving population.
- Provides surveillance and assessment of medical and nursing needs, including the needs of vulnerable population groups (infants, elderly, homeless), within an assigned community.
- Identifies status of existing and new community resources facilitates utilization of persons and resources to meet identified community health needs.
- Identifies ability of local resources to function during and after the disaster.
- Directs support staff.
- Participates as a key member of Public Health Assessment/Response Team that may include staff from Mental Health, Environmental Health, Social Services and others.
- Provides community education.
- Assesses safety of occupants in individual and aggregate living situations; plans with others to assist individuals without housing.
- Participates in the operation of treatment and first aid stations in areas where physicians are not available, possibly including assessment and treatment of minor illnesses and injuries, life-saving measures and referral of serious cases using standardized procedures, which may be modified as appropriate for specific localities and approved for use by staff using the local process for standardized procedures.
- Assists neighboring health facilities to function and provide public health consultations as needed.

Support staff:

- Provide outreach to special populations.
- Provide translation services.
- Assist with information and education.
- Deliver supplies and equipment.
- Assist with other tasks assigned by the Public Health Nurse.
- Perform clerical duties as assigned.
- Assist with data collection and processing.

The PHN staff plays a critical role in protecting the community from the spread of communicable disease following an environmental disaster. A disaster that damages housing on a large scale will result in the establishment of many kinds of aggregate living situations. Official Red Cross Shelters have existing standards for communicable disease control. Other group living settings may not have standards developed or experience in health matters.

Special shelter activity:

- Wear identification badge and/or other identifiers at all times.
- Strive to maintain cooperative working relationships with shelter managers and staff.
- Provide written documentation of:
  1. Visits to shelters or other group living situations.
  2. Consultation and training on communicable disease control given to shelter staff.
- Assess adequacy of hand washing and toilet facilities in the area.
- Provide written materials on communicable disease control, particularly hand washing.
- In cooperation with the Health Officer and Environmental Health, determine when the risk of communicable disease requires action by the Health Department to take remedial action or to close the shelter.

Special immunization activity:

- Consult with the Health Officer regarding the need for special immunization services, particularly regarding decisions on administration of Gamma Globulin.
- Maintain existing immunization services and develop additional services based on need.
- Set up and participate in immunization clinics when requested.
- Serve as resource to the Community for immunization recommendations and advice.
- Provide education regarding the need for immunizations and prevention of communicable disease.

References

Emergency Management. 4 Kan. Stat. Ann. §§ 49-904-911 (1994).

Disaster Manual for Public Health Nursing in California (1996, May). Developed by the California Conference of Local Health Department Nursing Directors.

Bioterrorism Response

As a consequence of the events of September 11, 2001, and the anthrax-contaminated letter threats later that fall, health departments across the nation have recognized more fully their role in preparedness and response to what are often termed acts of "bioterrorism" (BT).

Loosely defined, BT refers to the deliberate development and dissemination of pathogenic organisms on an immune-naïve population, with the intention of disrupting the target nation. Society, or community through increased morbidity and mortality; with fear, resource depletion, and economic standstill seen as desired secondary effects.

Beginning early in 2002, all health departments in Kansas participated in developing and implementing plans for local and regional response to BT events. Included in these activities were self-administered tools to measure infrastructure needs and weaknesses. Each health department should maintain a copy of the "Public Health Preparedness and Response Capacity Inventory". Often referred to as the "PHPPO Assessment". This inventory, first performed in deficiencies uncovered on the assessment should be scheduled for timely correction. Each health department should also have a local plan for BT response. Typically patterned after a template provided by KDHE, this plan should be scheduled for regular review. Additionally, health department's are expected to coordinate joint training exercised with local emergency operations plans which involve as many local partners as can be identified.

At the time this document was prepared, funding for BT preparedness and response was being provided by the Federal Government, through the Centers for Disease Control and Prevention. These funds were funneled through the BT Program at KDHE. Funding was initiated in 2002, and was anticipated to continue through 2004. The initial round of funding included grants to individual counties, with additional monies earmarked for the development of cooperative preparedness and response efforts termed "regionalization efforts."

Key Points:

- Health Department planning for BT response should be incorporated into generic County Emergency Response Plans.
- Repeated self-assessment using a standard tool (e.g., PHPPO) is an objective method of measuring infrastructure needs/weaknesses
- Training in department responsibilities and individual staff roles must be ongoing; while participation in multi-department or multi-county joint exercises is useful in revealing BT plan area needing improvement
- Future funding is uncertain; therefore, planning should incorporate systems and collaborations that are low-cost and self-sustaining rather that allocations-dependent.

Quality Management in Public Health

Why have Quality Management?

To assure that an agency's products/services are evaluated for the quality that meets or exceeds the customer's needs and expectations and results in positive health outcomes. An agency's Mission Statement should be the basis for its quality management program.

Brief History of Quality Measurement:

Quality is a relative term that defines something of high merit or excellence. Excellence compared to what? Quality must be measured to some standard. During the past 40 years, serious efforts have been made to set standards for measuring and monitoring health care services to ensure that quality care is provided.

The quality improvement process is a customer-focused process. Quality care means that the services provided match/meet of the populations(s), are technically correct, and achieve beneficial results. The escalating costs of health care have caused consumers and third party payors to demand quality care at reasonable costs. These demands are here to stay and more and more frequently, health care entities are being required to demonstrate beneficial outcomes in measurable terms. To say it simply, the public and payors want to know, "what am I getting for my money?"

Formal quality management activities in health care began in earnest in the early 1970's. Accrediting bodies focused most of their attention on hospitals at that time and formally instituted quality assessment (QA) program requirements for them in 1981. During the 80's, these requirements were expanded to include other entities such as ambulatory care, long-term care, and home health care. Although several methods for determining quality in public health have been developed, the public health system has been slow to uniformly adopt and/or use them. It is hoped, as the health care reform movement requires accountability in public health, that the following information will be instrumental in establishing formal quality management programs in public health in Kansas.

Model Descriptions

QUALITY Assurance Model:

Quality assurance (QA) programs were the forerunners of today concepts of quality management or continuous quality improvement (QCI). QA programs usually rely on objective, professional indicators, without subjective data on patient and family perceptions of care. QA programs are directed towards identifying the organizations activities, establishing standards for the activities, measuring performance against the standards, identifying the person(s) responsible for failure to meet the standards, and instituting desired changes. It is impossible to establish standards to measure every aspect of every activity, so health care providers identify "critical indicators" which are 1) representative of the services provided, 2) believed to be an indication that the services are being provided in an acceptable manner, and 3) are measurable. Usually four to six indicators are identified for each service. Because this process can be time consuming, a written Quality Assurance Plan must be established which describes when each service is to be monitored, the person(s) responsible for monitoring, and the activities they are to conduct. Indicators or measurable variables relate to the structure, process, or outcome of care. Thresholds are pre-established percentages of compliance that are set for each indicator. Usually aspects of care to be monitored include those considered to be high volume, high-risk, high cost, or high problem areas. The QA system, in public health, has focused on measuring the quantity of personal health services provided with the status quo outcome. Its weakness is that it fails to measure the extent to which public health's functions are being successfully addressed or any improvement in core function-related performance.

Q.A. Steps:

1. Identify units of service such as Family Planning, Healthy Start, and Disease Control.
2. Establish critical indicators for each service.
3. Establish standards for each critical indicator.
4. Establish a threshold for each standard (% of time the standard must be met to meet acceptable performance).
5. Identify data to be collected and measured.
6. Establish the method for collecting data (record review, etc.)
7. Establish a time frame for collecting data (daily, monthly, quarterly).
8. Collect the data.
9. Identify any indicator that does not meet the threshold.
10. Design a study to identify why performance did not meet standard.
11. Propose solutions; select the best choice.
12. Implement the solution.
13. Reevaluate the performance; if it is satisfactory, the process is complete. If not, repeat the process beginning at Step 10.

Q.A. Example: **Immunizations**

Standard:
All appropriate vaccines shall be given at each client visit.
Threshold:
100% of the time.
Data Collection:
Client records will be reviewed after each clinic visit to identify needed/administered vaccines.

It is apparent that the focus in this type of monitoring is on the practitioner and not necessarily the outcome. The IOM recommends that although a greater emphasis should be on outcomes of the care provided, outcome measurement should never fully replace process-of-care assessment.

Continuous Quality Improvement Model:

Continuous Quality Improvement (CQI) is a process that incorporates the PDCA cycle (plan, do, check, and act). It begins and ends with an assessment of performance. In public health practice, the community health needs assessment, which is an assessment of performance, is a dynamic and ongoing process reflecting a community system as opposed to a specific institution. CQI is a structured process that must involve agency employees in the planning and execution of improvements to provide quality health care that meets the needs of the public health customer. The process is focused on a problem or need instead of an indicator although indicators remain part of the measurement. The basic tenet of CQI is that improving processes will achieve far better results that finding people who cause the problems. Decisions for improving systems are based on facts, data, and statistical information. The process is ongoing and cyclic; it involves continuous evaluation and is always moving toward new levels with new standards. The prime difference between QA and CQI is that CQI emphasizes continuing improvement of performance and de-emphasizes whether or not a particular standard of performance was met. CQI has the goal of continuous improvement, reaching a level of performance never before achieved as opposed to the fixed goals of QA.

Performance measurement in the public health system must be able to measure inputs, processes, outputs, and outcomes in ways that allow for changes in one to be linked with the others. Without this, public health will not be able to make the changes necessary to improve the results it seeks. Public health has been extremely successful in measuring quantity (counting number served, procedures done, etc.), but

has had limited success in assessing improvements in programs or organizational capacities attributable to public health departments.

The APHEX*PH* manual has identified the following organizational capacities that are to be available in all local health departments, regardless of size. The capacities provide an optimal beginning for measuring quality on public health.

1. Authority to Operate
2. Community Relations
3. Community Health Assessment
4. Public Policy Development
5. Public Health Services
6. Financial Management
7. Personnel Management
8. Program Management
9. Policy Board Procedure

CQI Steps:

1. Identify desired outcomes, all customers, both internal and external, and their expectations. Answer, "what needs to be done?
2. "Describe the current steps in the process, what is to be done, and who is to do it.
3. Determine what measurements will be used to evaluate the quality of the product.
4. Focus on a way to improve the outcome.
5. Identify the causes of the problem; look at the processes in place.
6. Generate alternative solutions.
7. After choosing a solution, design it to fit your problem.
8. Implement a test period of the solution.
9. Evaluate the results; does it accomplish the desired outcome?
10. Implement the successful solution.
11. Standardize the change (check performance).
12. Monitor the change and hold the gains.

Figure 1. FDCA Model and for 12 Substeps. Source: Courtesy of the Einstein Consulting Group, 1990, Philadelphia, Pennsylvania.

CQI Examples:

Standard:
The local health department has the authority to operate.
Indicator:

A. Legal Authority:
    1. The health department has clear authority to act as a law enforcement office for public health problems.
B. Legal Counsel:
    1. The health department has legal counsel sufficient to provide advice as needed on administrative practices; department powers, duties, policies, and procedures; relevant laws and ordinances; contracts and other legal matters.

FROM THE ONSET, IT IS RECOMMENDED THAT ANYONE INTENDING TO BEGIN A QUALITY MANAGEMENT PROGRAM SHOULD ATTEND CONTINUING EDUCATION ON THE TOPIC. THIS SECTION SERVICES AS A GUIDE AND IT IS NOT INTENDED TO BE USED AS THE SOLE RESOURCE IN ESTABLISHING A QUALITY MANAGEMENT PROGRAM.

Definitions

Capacity – the capability to carry out the core functions of public health.

Customer – people who receive and use the work products or services of an organization. This can be a community, population, or families and individuals.

Inputs – capacities such as human resources, fiscal and physical resources, information resources, and system organizational resources necessary to carry out the core functions of public health.

Mission Statement – statement of the purpose of the organization; why the organization exists. For public health, it is assuring conditions in which people can be healthy.

Outcomes – the results of care for patients and populations based on long term objectives that define optimal, measurable future levels of health status.

Output – a product or service that is produced as part of the job and is passed on to the customer.

Process – a logical organization of people, materials, energy, equipment, and procedures into work activities designed to produce a specified end result, i.e. what is done to and for the patient.

Quality – meeting and exceeding the customers' needs and expectations, the first time and every time, keeping in mind that the customer's needs and expectations are not static.

Quality of care – the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.

Structure – characteristics of the providers or organizations delivering care, that is, the "inputs" to care.

Variability – the degree to which things are different from one another.

Quality Management – a management process that focuses on meeting customer needs, continuous improvement, and employee involvement.

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Formation of Local Health Department Advisory Council

Among the statutory requirements to meet the conditions of participation for home health agencies is to have an advisory council. However, certainly health departments as a whole can benefit from such a structure.

The advisory council should be outside the legal framework of the agency and without decision-making power. It would serve in an advisory capacity to the local health department and board of health. Through this group, the community learns what the local health department has done, is doing, and is planning for the future to meet the public health needs of the community.

Regular meetings with a written agenda for this council should be planned. Meetings should be held at a frequency which is great enough to keep the council informed and seek their assistance—but not so often that there is no purpose to the meetings. Quarterly meeting may be a good beginning.

Membership should represent the geographic area served. Examples of membership might be:

- physician representing the local medical practicing physicians
- minister
- attorney
- nurse employed outside of the agency
- business/industry leader
- school representative
- local government representative
- homemaker
- consumer of service
- accountant
- board of health member representative

The council should have no fewer than nine and no greater than twenty-five members depending on the population of the area served. It would be wise to make an effort for all commission districts to be represented in the membership. Summarizing some of the functions of this council might be as follows:

1. Advise and recommend policy.
2. Suggest the expansion of the geographic area served or services provided.
3. Evaluate programs, services, adequacy of facilities, and staffing.
4. Act as liaison between the agency and public.
5. Create public understanding and support.
6. Initiate the development of volunteer services.
7. Maintain a display booth at community fairs and functions.
8. Monitor legislation affecting community health.

Basic Responsibilities of Nonprofit Boards

1. Determine the organization's mission and purpose.
2. See that the organization achieves its stated mission and objectives.
3. Determine and monitor the organization's programs and services.
4. Ensure effective organizational planning.
5. Organize the work to be done, including the appointment of committees.
6. Determine the organization's policies.
7. Select the executive.
8. Support the executive and review his/her performance.
9. Ensure adequate resources, including raising and managing the organization's funds, property, and equipment.
10. Enhance the organization's public image.
11. Serve as a court of appeals.
12. Assess its own performance.
13. Ensure leadership development throughout the organization, but particularly on the board itself.
14. Ensure that basic legal and ethical responsibilities are fulfilled.

References

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Why Boards Fail: A Checklist for Your Organization

In his book *How to Organize and Raise Funds for Small Non-Profit Organizations*, (1979), David Long discusses reasons why boards fail to operate effectively. When boards fail, the entire organization is at risk of failing. Long identifies several recurring, underlying reasons why some boards have failed. Taken together, they provide a checklist for evaluating your own organization's potential trouble spots.

1. **Boards may fail because of an ineffective nominating committee**. The strategic importance of this committee, according to Long, often gets overlooked. Some groups fail consistently to realize that decisions made by the nominating committee will largely determine who will lead the group in the years ahead. This committee should be well organized, have a time schedule, and have planned working procedures.
2. **Boards may fail because members do not have a good understanding of the organization and what their role is**. This can happen when the nominating committee does not accurately interpret to potential board members what their responsibilities will be.
3. **Boards may fail because they have no planned rotation**. If the same people serve year after year, there can be no new blood. Despite dedication on their part, the same old people may make the organization a "closed corporation." Rotation prevents the in-grown possessiveness sometimes found on self-perpetuating boards.
4. **Boards may fail when no effective way of eliminating nonproductive members is provided**. The nominating committee could evaluate each board member on an annual basis, review his or her participation and interest, and make appropriate recommendations as to his/her reelection. Between elections, organizations should develop and use accountability structures.
5. **Boards may fail because they are too small**. It is hard to conceive of a board getting the job done if it is simply too small.
6. **Boards may fail when they have not established standing committees**. Standing committees should operate year round.
7. **Boards may fail because they have no well-planned orientation for new and old members**. Deliberate thought needs to be given to the matter of integrating new board members. Experienced board members need an annual update on the organization's work and accomplishments. All board members, new and experienced, need a chance to step back and reflect together on future plans in an atmosphere that allows no interruptions.
8. **Boards may fail because they have no long-range financial and service delivery plan**. A three- to five-year plan for organization is recommended. This introduces the concepts of planned growth and management by objectives.
9. **Boards may fail because they do not have a process for self-evaluation**. Once a year the board and the staff should thoroughly evaluate the goals, accomplishments, and problems of each committee as it relates to the program. This annual process should be tied into the long-range planning process as well.

References

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Some Group Dynamics Issues for Boards and Committees

The field of group dynamics/human relations has much to teach those of us who serve on boards and committees and must make decisions in a group setting. Among some of the important issues are:

1. **It is important to realize that each of us plays a role in each gathering of the group** (board, committee). Sometimes we play multiple roles. Some roles are related to the task or "business at hand." Such roles include the functions of seeking information (being willing to appear "dumb"), providing information, offering opinions relative to the merits of what is being discussed, clarifying and/or elaborating on the material involved in the discussion, synthesizing ideas, and summarizing the discussion. It isn't only the presiding officer who is charged with these functions.

   Besides the task functions, there are numerous functions and roles which serve to build the group as a functioning unit, to build trust among the members of the group (which helps the group make better decisions). Such roles include "gatekeeping" (helping others to make a contribution to the discussion); "following" (thoughtfully accepting ideas of others), and summarizing apparent group feeling.

   Other functions that accomplish task and group maintenance objectives are diagnosing (determining sources of difficulties and analyzing the main blocks to progress), testing for consensus, mediating (trying to conciliate differences), and relieving tension (when appropriate).

   Nonfunctional behavior includes being aggressive, blocking the progress of the group by going off on a tangent, self-confessing (using the group as a sounding board inappropriately), competing, horsing around, and withdrawing from the discussions (e.g., by whispering to others or daydreaming).

2. **Groups work on two levels: the level of the "task" or agenda and the level of hidden, undisclosed needs and motives of the individual members.** Everyone has personal needs, some more apparent than others. These personal needs do not always cause a problem in a group, but sometimes there are needs which are in conflict with the purpose of the group and/or which are in conflict with other individuals in the group. If these needs get in the way of the group purpose, they need to be dealt with, usually by the presiding officer, but sometimes by an alert member of the group who can try to surface the "hidden agenda."

3. **We live in a society dominated by a win-lose philosophy.** This win-lose climate can contaminate group process to the point that individual members of the group try to get their point of view adopted at all costs. My personal favorite antidote to win/lose is to choose to believe that everyone is "partly right." In that way, we can respect each person's input; we can truly listen to another's point of view when it differs from our own and take the chance that we may then have to change our point of view somewhat. "Active listening" is a learnable skill and ought to be on all board training agendas because it is a skill most notable in its absence at group meetings.

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Collaboration

Definition:
Collaboration occurs when two or more parties/agencies, which are not directly connected, establish a working relationship in a cooperative effort that is in their mutual interest, and allows them to put their ideas and resources together to accomplish a particular objective.

Collaborative undertakings are complicated. In reality, many times potential partners come to the table to achieve their own agenda and/or to protect their turf. To be successful, each partner must be willing to compromise; each gains from and each gives to the others. All collaborations must have some common ground. This may become threatening to the partners, if they perceive that another party will take them over.

Differences among partners work because they each contribute complementary resources, skills, and expertise to the endeavor. By bringing diverse building blocks together, the group is able to achieve results that no single partner could achieve alone.

Tensions can develop when partners have different "languages" and values as well as different resources and skills. In these situations, the viability of the collaboration depends on its capacity to foster tolerance, respect, and trust. When partners are very foreign to each other, it is important to engage in a narrowly focused, noncontroversial project that can lead to short-term benefits.

For Collaborative Efforts to Succeed:

- All partners should be involved in the enterprise from the planning stage.
- Partners roles and responsibilities (what each is expected to contribute) and clarified early in the endeavor.
- The partners must perceive a compelling need to work with professionals/organizations in other sectors, and be willing to do so.
- The potential partners must value the enterprise that they enter with the partners.
- The benefit for each partner must be expected to be worth the investment and commitment.
- Partners must recognize that they do not have to agree about everything to work together; but they must find common ground.
- Don't expect other partners to be like you.
- Potential partners must have confidence and trust in the leaders of the enterprise.
- The partners seek to achieve early success, then build on that to extend further collaboration.
- Partners must be cognizant of each other's burdens; financial contributions expected of each partner must be realistic, administrative support must be adequate, and partners should take on the roles that they do best and most efficiently.
- When partners are very different, it may be valuable to identify a neutral, skilled facilitator who has the trust and respect of al partners.
- Be up front about competition and control issues.
- There must be effective strategies for promoting understanding and communication, for building a common language, for fostering trust and respect, for supporting group decision making, for keeping partners fully informed about what is happening, for learning about each other's concerns, values, and work, for airing disagreements, and for responding to changes and emerging problems.

Obstacles/Barriers to Success:
Collaborations fail for a variety of reasons:

- Most collaborations fail because of relationships; confidence and trust between partners dissipated, they are separated by deep cultural difference, they are competitors, and they lack a history of working together.

- Partners are concerned about losing control; over their professional and institutional destinies, over the direction of the collaboration, over the limits of their participation, and because they fear their partners will attempt to take them over.
- Policy barriers include requirements of health programs, strings attached to funding streams, and market forces that threaten funding for research, professional training, and population based health programs.

Benefits for the partners and the clients of health care agencies can be greatly enhanced through community collaborations. This pursuit of self-interest within the context of the collaborative enterprise needs to be limited; benefits for one partner cannot be achieved at the expense of others.

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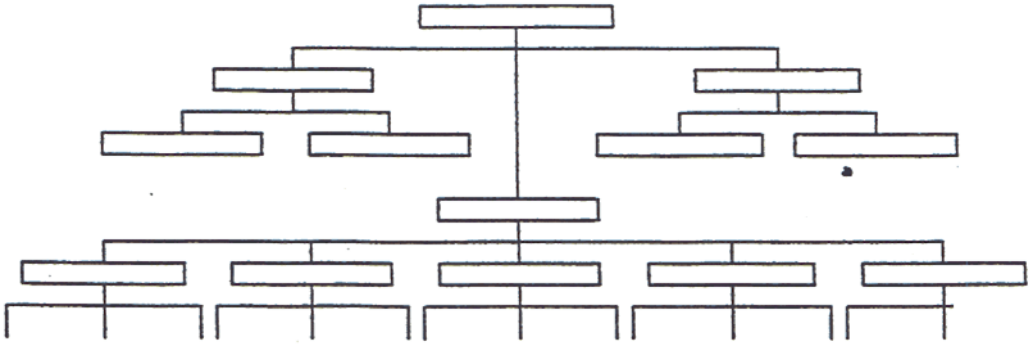
Organizational Charts

An important principle of organization is unity of command. Each employee should have only one superior to whom he or she is directly responsible for certain matters.

A written statement of duties, responsibilities, authority, and relationship should be provided each employee.

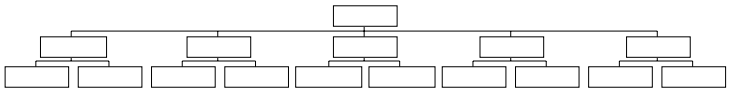
There is no magical organizational structure, use whatever structure seems to make sense to you in your situation. The test is: Does it work at an acceptable cost? The people, not the form, should be concentrated on because they are the key factor, an organizational chart is not only a useful tool for the present, but also an aid in planning for the future development of your organization, and in projecting personnel requirements. One reason for charting an organization concerns the discovery and cure of 'organizational defects' – conflicts, duplications, and burdensome spans of control become apparent.

You may select a traditional formal organizational structure that may be described as a triangular pyramid. This relationship provides for a tight and narrow span of control. It requires centralization of authority and detailed supervision. (Example 1).



EXAMPLE 1. TRIANGULAR PYRAMID

The Flatter, broader span of control will provide less centralized authority, less detailed supervision, and more responsibility. (Example 2).



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Tate, C.E., Megginson, L.C., Scott, C.R. Jr., & Trueblood, L.R. (1985). Successful Small Business Management. Plano, TX: business Publications.

White, K.K. (1963). Understanding the Company Organization Chart. New York: American Management Association.

Objectives

Objectives provide direction for action. They are statements of specific and measurable items that articulate how much will be accomplished and by when the results will be anticipated. They have baselines that use valid and reliable data derived from established data systems. The following should be true of all objectives:

The results to be achieved should be important and understandable.

Objectives should drive action and suggest a set of interim steps that will achieve the proposed targets within the specified time frame.

Objectives should be useful and relevant.

Objectives should be measurable and may include a range of measures, i.e. immediate, intermediate, and long-range.

All objectives have specific and necessary elements:

1. A target date, e.g. "by June 30, 1998…."
2. A focused issue, e.g. "immunization rates," or "personnel policies."
3. A measurable change, e.g. "achieved completion rates of 92%," or "reviewed and revised in accord with new county policies."
4. Baseline measures, e.g. "74% completion rate in 1996."
5. And in some cases a targeted population, e.g. .."children at 24 months of age.."

Health objectives are organized into three types:

Health Status/Outcome – Objectives that state the intended result of activities to reduce death, disease, and disability. Outcomes are long-term and define the optimal, measurable future levels of health. Example: Reduce deaths due to unintentional injuries.

Risk Outcome – Objectives to reduce the prevalence of risks to health or to increase behaviors known to reduce such risks. These are intermediate in nature, usually 2 to 5 years. Example: Increase the percent of persons wearing seat belts.

Process – Objectives that identify the activities, which are instituted to move a community toward a risk or outcome objective. Example: Institute community awareness program with the Highway Patrol.

Writing Behavioral Objectives

A behavioral objective is a statement of intended change in a learner's behavior as a result of the educational experience and these objectives are observable or measurable. Behavioral objectives are generally classified as occupying one of three domains: cognitive (intellectual), affective (attitudinal or emotional), and psychomotor (motor skills or doing). All learning outcomes are believed to fit within one of these domains.

Benefits of behavioral stated objectives are:

1. They provide direction for the instructor/health educator as well as indicating to students the instructional intent of the program.
2. They facilitate and guide selection of course content, teaching strategies, and supplemental materials by the instructor.
3. They facilitate the evaluation process at the end of the program.
4. They guide the student's selection of education to meet their learning needs and outline results expected to be accomplished by the program.

Key points for writing behavioral objectives are:

1. Begin each objective with an action verb, such as "describe," "identify," "analyze," "list," or "demonstrate." Verbs such as "knows," "understands," or "appreciates" are not appropriate because they are not observable or measurable.
2. Be sure the objective is stated as a learner performance outcome rather than as a teacher action or intent (What can the student do at the end of the program as a result of the program?)
3. Include only one desired behavior per objective.
4. Be sure the stated objectives are appropriate to the learner's needs, interests and knowledge base.

Suggested action verbs to use when writing behavioral objectives:

identity	state	discuss	list
classify	examine	differentiate	compare/contrast
outline	interpret	construct	assess/document
recall	order	relate	translate
describe	distinguish	apply	demonstrate
analyze	recognize	explain	define

Use the verb with a stem statement, such as, "Upon completion of the program, the participant will be able to…" at the beginning of the objectives.

Upon completion of this workshop, the nurse participant will be able to:

1. Discuss current research on senile dementia.
2. Identify clinical needs of elderly patients with mental disturbances.
3. Construct a nursing management plan for elderly patients with dementia.
4. Explain practical concerns and management techniques for elderly patients with mental impairment.

Community Health Assessment

The assessment process has become increasingly important in determining priority objectives, program planning, funding, and policy formulation for any defined service area. Social mobilization in support of public health objectives will happen with community involvement through the community assessment process.

Several models for community health assessment are in use. The PATCH Process was initiated and later revised by CDC and focuses well on getting the community working together on health promotion and risk reduction activities. The Assessment Protocol for Excellence in Public Health (APEX*PH*) is a product of NACCHO (National Association of County and City Health Officials) and is particularly suited to better define the public health agency's leadership role in the community and establish a wide range of intervention strategies. The Kansas Community Health Assessment Process (CHAP) was written especially for Kansas and has been adapted to the needs of Kansas's communities. Materials and technical assistance for this process are available through KDHE.

The CHAP process is:

- **community-controlled** – CHAP is performed **by** a community, not **to** it.
- **data-driven –** CHAP guides the community members in collecting and interpreting data to make informed decisions.
- **comprehensive** – CHAP incorporates a broad range of community data and guides the community in assessment and planning.

According to CHAP, community health assessment is a process of collecting and using information the helps define the community's problems and determine what that community can do about them. The long-term goal of Community Health Assessment is to improve and promote the health of community members.

For more information on the CHAP process or for printed materials, call KDHE Office of Local and Rural Health at 785-296-1200.

References

American Public Health Association (1993). Model Standards Project: The Guide to Implementing Model Standards. Washington, DC: Author.

Kansas Community Health Assessment Process Workbook (1995 March). Topeka, KS: Kansas Department of Health & Environment, Office of Local and Rural Health.

PUBLIC HEALTH NURSING PRACTICE

Standards

Kansas Nurse Practice Act: Definitions & Standards of Practice

http://www.ksbn.org/npatoc.htm

[PLEASE NOTE: THIS DOCUMENT CHANGES FREQUENTLY AND THIS ENTRY IS INTENDED FOR REFERENCE ONLY. FOR LEGAL QUESTIONS AND ISSUES OR TO REQUEST A COMPLETE CURRENT COPY, CONTACT THE KANSAS STATE BOARD OF NURSING, LANDON STATE OFFICE BUILDING, 900 SW JACKSON, SUITE 1051, TOPEKA, KS 66612-1230. PHONE (785) 296-4929.

65-1113 Definitions http://www.ksbn.org/npa/pages/65-1113.doc

65-1114 Unlawful Acts http://www.ksbn.org/npa/pages/65-1114.doc

65-1115 Licensure of professional nurses; qualifications of applicants; examination; refresher course; title and abbreviation; temporary permit; exempt license. http://www.ksbn.org/npa/pages/65-1115.doc

65-1116 Licensure of practical nurses; qualifications of applicants; examination; refresher course; title and abbreviation; temporary permit; exempt license. http://www.ksbn.org/npa/pages/65-1116.doc

65-1117 Renewal of licensees; continuing education requirements; rules and regulations. http://www.ksbn.org/npa/pages/65-1117.doc

65-1120 Denial revocation, limitation or suspension of license or certification of qualification; costs; professional incompetency defined. http://www.ksbn.org/npa/pages/65-1120.doc

65-1121a Judicial review of board's actions. http://www.ksbn.org/npa/pages/65-1121a.doc

65-1122 Misdemeanors; penalties. http://www.ksbn.org/npa/pages/65-1122.doc

65-1123 Injunctions. http://www.ksbn.org/npa/pages/65-1123.doc

Acts which are not Prohibited

65-1124 Acts which are not prohibited. http://www.ksbn.org/npa/pages/65-1124.doc

65-1126 Invalidity of part. http://www.ksbn.org/npa/pages/65-1126.doc

65-1127 Immunity from liability in civil actions for reporting, communicating and investigating certain information concerning alleged malpractice incidents and other information; conditions http://www.ksbn.org/npa/pages/65-1127.doc

65-1129 Rules and Regulations http://www.ksbn.org/npa/pages/65-1129.doc

65-1135 Complaint or information relating to complaint confidential; exceptions. http://www.ksbn.org/npa/pages/65-1135.doc

65-1165 Supervision of delegated nursing procedures. http://www.ksbn.org/npa/pages/65-1165.doc

Requirements for Licensure and Standards of Practice

60-3-101 Licensure. http://www.ksbn.org/npa/pages/60-3-101.doc

60-3-102 Duplicate of license. http://www.ksbn.org/npa/pages/60-3-102.doc

60-3-103 Change of name. http://www.ksbn.org/npa/pages/60-3-103.doc

60-3-105 Reinstatement of license. http://www.ksbn.org/npa/pages/60-3-105.doc

60-3-106 Licensure qualifications. http://www.ksbn.org/npa/pages/60-3-106.doc

60-3-106a Temporary permit. http://www.ksbn.org/npa/pages/60-3-106a.doc

60-3-107 Expiration dates of licenses; applications. http://www.ksbn.org/npa/pages/60-3-107.doc

60-3-108 Expiration date of initial or reinstated license. http://www.ksbn.org/npa/pages/60-3-108.doc

60-3-109a Standard of practice. http://www.ksbn.org/npa/pages/60-3-109a.doc

60-3-110 Standards of revocation, suspension, limitation, or denial of nursing licensure. http://www.ksbn.org/npa/pages/60-3-110.doc

60-3-111 Inactive license. http://www.ksbn.org/npa/pages/60-3-111.doc

60-4-101 Payment of fees. http://www.ksbn.org/npa/pages/60-4-101.doc

Continuing Education for Nurses

60-9-105 Definitions. http://www.ksbn.org/npa/pages/60-9-105.doc

60-9-106 License renewal. http://www.ksbn.org/npa/pages/60-9-106.doc

60-9-107 Approval of continuing nursing education. http://www.ksbn.org/npa/pages/60-9-107.doc

Performance of Selecting Nursing Procedures in School Settings

60-15-101 Definitions and functions. http://www.ksbn.org/npa/pages/60-15-101.doc

60-15-102 Delegation procedures. http://www.ksbn.org/npa/pages/60-15-102.doc

60-15-103 Supervision of delegated tasks or procedures. http://www.ksbn.org/npa/pages/60-15-103.doc

60-15-104 Administration of medications in the school setting. http://www.ksbn.org/npa/pages/60-15-104.doc

American Nurses Association
Code of Ethics for Nursing

The Code of Ethics for Nursing is located at the following web page for viewing http://www.ana.org/ethics/code/ethicscode150.htm or maybe purchased online at http://nursingworld.org/anp/pdescr.cfm?cnum=5.#CEN21.

American Nurses Association Standards of Clinical Nursing Practice

When professional nursing organizations develop standards of practice, they are establishing a framework for delivery of care and assurance of quality outcomes. Used in legal arenas, such standards serve a different purpose, illustrating inadequacies and incompetence. By considering the legal aspects of the practice, this text provides a basis for determining liability when standards have been allegedly compromised. To purchase book for go to: http://nursingworld.org/books/pdescr.cfm?CNum=9#9805NP

Role of Public Health Nursing

Scope and Standards of Public Health Nursing Practice

Preface

Ethics is an integral part of the foundation of nursing. Nursing has a distinguished history of concern for the welfare of the sick, injured, and vulnerable and for social justice. This concern is embodied in the provision of nursing care to individuals and the community. Nursing encompasses the prevention of illness, the alleviation of suffering, and the protection, promotion, and restoration of health in the care of individuals, families, groups, and communities. Nurses act to change those aspects of social structures that detract from health and well being. Individuals who become nurses are expected not only to adhere to the ideals and moral norms of the profession but also to embrace them as a part of what it means to be a nurse. The ethical tradition of nursing is self-reflective, enduring, and distinctive. A code of ethics makes explicit the primary goals, values, and obligations of the profession.

The Code of Ethics for Nurses serves the following purposes:

- It is a succinct statement of the ethical obligations and duties of every individual who enters the nursing profession.
- It is the profession's nonnegotiable ethical standard.
- It is an expression of nursing's own understanding of its commitment to society.

There are numerous approaches for addressing ethics; these include adopting or subscribing to ethical theories, including humanist, feminist, and social ethics, adhering to ethical principles, and cultivating virtues. The Code of Ethics for Nurses reflects all of these approaches. The words "ethical" and "moral" are used throughout the Code of Ethics. "Ethical" is used to refer to reasons for decisions about how one ought to act, using the above mentioned approaches. In general, the word "moral" overlaps with "ethical" but is more aligned with personal belief and cultural values. Statements that describe activities and attributes of nurses in this Code of Ethics are to be understood as normative or prescriptive statements expressing expectations of ethical behavior.

The Code of Ethics for Nurses uses the term patient to refer to recipients of nursing care. The derivation of this word refers to "one who suffers," reflecting a universal aspect of human existence. Nonetheless, it is recognized that nurses also provide services to those seeking health as well as those responding to illness, to students and to staff, in health care facilities as well as in communities. Similarly, the term practice refers to the actions of the nurse in whatever role the nurse fulfills, including direct patient care provider, educator, administrator, researcher, policy developer, or other. Thus, the values and obligations expressed in this Code of Ethics apply to nurses in all roles and settings.

The Code of Ethics for Nurses is a dynamic document. As nursing and its social context change, changes to the Code of Ethics are also necessary. The Code of Ethics consists of two components: the provisions and the accompanying interpretive statements. There are nine provisions. The first three describe the most fundamental values and commitments of the nurse; the next three address boundaries of duty and loyalty, and the last three address aspects of duties beyond individual patient encounters. For each provision, there are interpretive statements that provide greater specificity for practice and are responsive to the contemporary context of nursing. Consequently, the interpretive statements are subject to more frequent revision than are the provisions. Additional ethical guidance and detail can be found in ANA or constituent member association position statements that address clinical, research, administrative, educational, or public policy issues.

The Code of Ethics for Nurses with Interpretive Statements provides a framework for nurses to use in ethical analysis and decision-making. The Code of Ethics establishes the ethical standard for the profession.

It is not negotiable in any setting nor is it subject to revision or amendment except by formal process of the House of Delegates of the ANA. The Code of Ethics for Nurses is a reflection of the proud ethical heritage of nursing, a guide for nurses now and in the future.

Provision 1.

The nurse, in all professional relationships, practices with compassion and respect for the inherent dignity, worth, and uniqueness of every individual, unrestricted by considerations of social or economic status, personal attributes, or the nature of health problems.

1.1 **Respect for human dignity** - A fundamental principle that underlies all nursing practice is respect for the inherent worth, dignity, and human rights of every individual. Nurses take into account the needs and values of all persons in all professional relationships.

1.2 **Relationships to patients** - The need for health care is universal, transcending all individual differences. The nurse establishes relationships and delivers nursing services with respect for human needs and values, and without prejudice. An individual's lifestyle, value system and religious beliefs should be considered in planning health care with and for each patient. Such consideration does not suggest that the nurse necessarily agrees with or condones certain individual choices, but that the nurse respects the patient as a person.

1.3 **The nature of health problems** -The nurse respects the worth, dignity and rights of all human beings irrespective of the nature of the health problem. The worth of the person is not affected by disease, disability, functional status, or proximity to death. This respect extends to all who require the services of the nurse for the promotion of health, the prevention of illness, the restoration of health, the alleviation of suffering, and the provision of supportive care to those who are dying.

The measures nurses take to care for the patient enable the patient to live with as much physical, emotional, social, and spiritual well-being as possible. Nursing care aims to maximize the values that the patient has treasured in life and extends supportive care to the family and significant others. Nursing care is directed toward meeting the comprehensive needs of patients and their families across the continuum of care. This is particularly vital in the care of patients and their families at the end of life to prevent and relieve the cascade of symptoms and suffering that are commonly associated with dying.

Nurses are leaders and vigilant advocates for the delivery of dignified and humane care. Nurses actively participate in assessing and assuring the responsible and appropriate use of interventions in order to minimize unwarranted or unwanted treatment and patient suffering. The acceptability and importance of carefully considered decisions regarding resuscitation status, withholding and withdrawing life-sustaining therapies, forgoing medically provided nutrition and hydration, aggressive pain and symptom management and advance directives are increasingly evident. The nurse should provide interventions to relieve pain and other symptoms in the dying patient even when those interventions entail risks of hastening death. However, nurses may not act with the sole intent of ending a patient's life even though such action may be motivated by compassion, respect for patient autonomy and quality of life considerations. Nurses have invaluable experience, knowledge, and insight into care at the end of life and should be actively involved in related research, education, practice, and policy development.

1.4 **The right to self-determination** - Respect for human dignity requires the recognition of specific patient rights, particularly, the right of self-determination. Self-determination, also known as autonomy, is the philosophical basis for informed consent in health care. Patients

have the moral and legal right to determine what will be done with their own person; to be given accurate, complete, and understandable information in a manner that facilitates an informed judgment; to be assisted with weighing the benefits, burdens, and available options in their treatment, including the choice of no treatment; to accept, refuse, or terminate treatment without deceit, undue influence, duress, coercion, or penalty; and to be given necessary support throughout the decision-making and treatment process. Such support would include the opportunity to make decisions with family and significant others and the provision of advice and support from knowledgeable nurses and other health professionals.

Patients should be involved in planning their own health care to the extent they are able and choose to participate. Each nurse has an obligation to be knowledgeable about the moral and legal rights of all patients to self-determination. The nurse preserves, protects, and supports those interests by assessing the patient's comprehension of both the information presented and the implications of decisions. In situations in which the patient lacks the capacity to make a decision, a designated surrogate decision-maker should be consulted. The role of the surrogate is to make decisions as the patient would, based upon the patient's previously expressed wishes and known values. In the absence of a designated surrogate decision-maker, decisions should be made in the best interests of the patient, considering the patient's personal values to the extent that they are known. The nurse supports patient self-determination by participating in discussions with surrogates, providing guidance and referral to other resources as necessary, and identifying and addressing problems in the decision-making process. Support of autonomy in the broadest sense also includes recognition that people of some cultures place less weight on individualism and choose to defer to family or community values in decision-making. Respect not just for the specific decision but also for the patient's method of decision-making is consistent with the principle of autonomy.

Individuals are interdependent members of the community. The nurse recognizes that there are situations in which the right to individual self-determination may be outweighed or limited by the rights, health and welfare of others, particularly in relation to public health considerations. Nonetheless, limitation of individual rights must always be considered a serious deviation from the standard of care, justified only when there are no less restrictive means available to preserve the rights of others and the demands of justice.

1.5 **Relationships with colleagues and others** - The principle of respect for persons extends to all individuals with whom the nurse interacts. The nurse maintains compassionate and caring relationships with colleagues and others with a commitment to the fair treatment of individuals, to integrity-preserving compromise, and to resolving conflict. Nurses' function in many roles, including direct care provider, administrator, educator, researcher, and consultant. In each of these roles, the nurse treats colleagues, employees, assistants, and students with respect and compassion. This standard of conduct precludes any and all prejudicial actions, any form of harassment or threatening behavior, or disregard for the effect of one's actions on others. The nurse values the distinctive contribution of individuals or groups, and collaborates to meet the shared goal of providing quality health services.

Provision 2

The nurse's primary commitment is to the patient, whether an individual, family, group, or community.

2.1 Primacy of the patient's interests - The nurse's primary commitment is to the recipient of nursing and health care services--the patient--whether the recipient is an individual, a family, a group, or a community. Nursing holds a fundamental commitment to the uniqueness of the individual patient; therefore, any plan of care must reflect that uniqueness. The nurse strives to provide patients with opportunities to participate in planning care, assures that patients find the plans acceptable and supports the implementation of the plan. Addressing patient interests

requires recognition of the patient's place in the family or other networks of relationship. When the patient's wishes are in conflict with others, the nurse seeks to help resolve the conflict. Where conflict persists, the nurse's commitment remains to the identified patient.

2.2 **Conflict of interest for nurses -** Nurses are frequently put in situations of conflict arising from competing loyalties in the workplace, including situations of conflicting expectations from patients, families, physicians, colleagues, and in many cases, health care organizations and health plans. Nurses must examine the conflicts arising between their own personal and professional values, the values and interests of others who are also responsible for patient care and health care decisions, as well as those of patients. Nurses strive to resolve such conflicts in ways that ensure patient safety, guard the patient's best interests and preserve the professional integrity of the nurse.

Situations created by changes in health care financing and delivery systems, such as incentive systems to decrease spending, pose new possibilities of conflict between economic self-interest and professional integrity. The use of bonuses, sanctions, and incentives tied to financial targets are examples of features of health care systems that may present such conflict. Conflicts of interest may arise in any domain of nursing activity including clinical practice, administration, education, or research. Advanced practice nurses who bill directly for services and nursing executives with budgetary responsibilities must be especially cognizant of the potential for conflicts of interest. Nurses should disclose to all relevant parties (e.g., patients, employers, colleagues) any perceived or actual conflict of interest and in some situations should withdraw from further participation. Nurses in all roles must seek to ensure that employment arrangements are just and fair and do not create an unreasonable conflict between patient care and direct personal gain.

2.3 **Collaboration -** Collaboration is not just cooperation, but it is the concerted effort of individuals and groups to attain a shared goal. In health care, that goal is to address the health needs of the patient and the public. The complexity of health care delivery systems requires a multi-disciplinary approach to the delivery of services that has the strong support and active participation of all the health professions. Within this context, nursing's unique contribution, scope of practice, and relationship with other health professions needs to be clearly articulated, represented and preserved. By its very nature, collaboration requires mutual trust, recognition, and respect among the health care team, shared decision-making about patient care, and open dialogue among all parties who have an interest in and a concern for health outcomes. Nurses should work to assure that the relevant parties are involved and have a voice in decision-making about patient care issues. Nurses should see that the questions that need to be addressed are asked and that the information needed for informed decision-making is available and provided. Nurses should actively promote the collaborative multi-disciplinary planning required to ensure the availability and accessibility of quality health services to all persons who have needs for health care.

Intra-professional collaboration within nursing is fundamental to effectively addressing the health needs of patients and the public. Nurses engaged in non-clinical roles, such as administration or research, while not providing direct care, nonetheless are collaborating in the provision of care through their influence and direction of those who do. Effective nursing care is accomplished through the interdependence of nurses in differing roles--those who teach the needed skills, set standards, manage the environment of care, or expand the boundaries of knowledge used by the profession. In this sense, nurses in all roles share a responsibility for the outcomes of nursing care.

2.4 **Professional boundaries** - When acting within one's role as a professional, the nurse recognizes and maintains boundaries that establish appropriate limits to relationships. While

the nature of nursing work has an inherently personal component, nurse-patient relationships and nurse-colleague relationships have, as their foundation, the purpose of preventing illness, alleviating suffering, and protecting, promoting, and restoring the health of patients. In this way, nurse-patient and nurse-colleague relationships differ from those that are purely personal and unstructured, such as friendship. The intimate nature of nursing care, the involvement of nurses is important and sometimes highly stressful life events, and the mutual dependence of colleagues working in close concert all present the potential for blurring of limits to professional relationships. Maintaining authenticity and expressing oneself as an individual, while remaining within the bounds established by the purpose of the relationship can be especially difficult in prolonged or long-term relationships. In all encounters, nurses are responsible for retaining their professional boundaries. When those professional boundaries are jeopardized, the nurse should seek assistance from peers or supervisors or take appropriate steps to remove her/himself from the situation.

Provision 3

The nurse promotes, advocates for, and strives to protect the health, safety, and rights of the patient.

3.1 **Privacy -** The nurse safeguards the patient's right to privacy. The need for health care does not justify unwanted intrusion into the patient's life. The nurse advocates for an environment that provides for sufficient physical privacy, including auditory privacy for discussions of a personal nature and policies and practices that protect the confidentiality of information.

3.2 **Confidentiality** - Associated with the right to privacy, the nurse has a duty to maintain confidentiality of all patient information. The patient's well-being could be jeopardized and the fundamental trust between patient and nurse destroyed by unnecessary access to data or by the inappropriate disclosure of identifiable patient information. The rights, well-being, and safety of the individual patient should be the primary factors in arriving at any professional judgment concerning the disposition of confidential information received from or about the patient, whether oral, written or electronic. The standard of nursing practice and the nurse's responsibility to provide quality care require that relevant data be shared with those members of the health care team who have a need to know. Only information pertinent to a patient's treatment and welfare is disclosed, and only to those directly involved with the patient's care. Duties of confidentiality, however, are not absolute and may need to be modified in order to protect the patient, other innocent parties and in circumstances of mandatory disclosure for public health reasons.

Information used for purposes of peer review, third-party payments, and other quality improvement or risk management mechanisms may be disclosed only under defined policies, mandates, or protocols. These written guidelines must assure that the rights, well-being, and safety of the patient are protected. In general, only that information directly relevant to a task or specific responsibility should be disclosed. When using electronic communications, special effort should be made to maintain data security.

3.3 **Protection of participants in research** - Stemming from the right to self-determination, each individual has the right to choose whether or not to participate in research. It is imperative that the patient or legally authorized surrogate receive sufficient information that is material to an informed decision, to comprehend that information, and to know how to discontinue participation in research without penalty. Necessary information to achieve an adequately informed consent includes the nature of participation, potential harms and benefits, and available alternatives to taking part in the research. Additionally, the patient should be informed of how the data will be protected. The patient has the right to refuse to participate in research or to withdraw at any time without fear of adverse consequences or reprisal.

Research should be conducted and directed only by qualified persons. Prior to implementation, all research should be approved by a qualified review board to ensure patient protection and the ethical integrity of the research. Nurses should be cognizant of the special concerns raised by research involving vulnerable groups, including children, prisoners, students, the elderly, and the poor. The nurse who participates in research in any capacity should be fully informed about both the subject's and the nurse's rights and obligations in the particular research study and in research in general. Nurses have the duty to question and, if necessary, to report and to refuse to participate in research they deem morally objectionable.

3.4 **Standards and review mechanisms** - Nursing is responsible and accountable for assuring that only those individuals who have demonstrated the knowledge, skill, practice experiences, commitment, and integrity essential to professional practice are allowed to enter into and continue to practice within the profession. Nurse educators have a responsibility to ensure that basic competencies are achieved and to promote a commitment to professional practice prior to entry of an individual into practice. Nurse administrators are responsible for assuring that the knowledge and skills of each nurse in the workplace are assessed prior to the assignment of responsibilities requiring preparation beyond basic academic programs.

The nurse has a responsibility to implement and maintain standards of professional nursing practice. The nurse should participate in planning, establishing, implementing, and evaluating review mechanisms designed to safeguard patients and nurses, such as peer review processes or committees, credentialing processes, quality improvement initiatives, and ethics committees. Nurse administrators must ensure that nurses have access to and inclusion on institutional ethics committees. Nurses must bring forward difficult issues related to patient care and/or institutional constraints upon ethical practice for discussion and review. The nurse acts to promote inclusion of appropriate others in all deliberations related to patient care.

Nurses should also be active participants in the development of policies and review mechanisms designed to promote patient safety, reduce the likelihood of errors, and address both environmental system factors and human factors that present increased risk to patients. In addition, when errors do occur, nurses are expected to follow institutional guidelines in reporting errors committed or observed to the appropriate supervisory personnel and for assuring responsible disclosure of errors to patients. Under no circumstances should the nurse participate in, or condone through silence, either an attempt to hide an error or a punitive response that serves only to fix blame rather than correct the conditions that led to the error.

3.5 **Acting on questionable practice** - The nurse's primary commitment is to the health, well-being, and safety of the patient across the life span and in all settings in which health care needs are addressed. As an advocate for the patient, the nurse must be alert to and take appropriate action regarding any instances of incompetent, unethical, illegal, or impaired practice by any member of the health care team or the health care system or any action on the part of others that places the rights or best interests of the patient in jeopardy. To function effectively in this role, nurses must be knowledgeable about the Code of Ethics, standards of practice of the profession, relevant federal, state and local laws and regulations, and the employing organization's policies and procedures.

When the nurse is aware of inappropriate or questionable practice in the provision or denial of health care, concern should be expressed to the person carrying out the questionable practice. Attention should be called to the possible detrimental affect upon the patient's well-being or best interests as well as the integrity of nursing practice. When factors in the health care delivery system or health care organization threaten the welfare of the patient, similar action should be directed to the responsible administrator. If indicated, the problem should be

reported to an appropriate higher authority within the institution or agency, or to an appropriate external authority.

There should be established processes for reporting and handling incompetent, unethical, illegal, or impaired practice within the employment setting so that such reporting can go through official channels, thereby reducing the risk of reprisal against the reporting nurse. All nurses have a responsibility to assist those who identify potentially questionable practice. State nurses associations should be prepared to provide assistance and support in the development and evaluation of such processes and reporting procedures. When incompetent, unethical, illegal, or impaired practice is not corrected within the employment setting and continues to jeopardize patient well-being and safety, the problem should be reported to other appropriate authorities such as practice committees of the pertinent professional organizations, the legally constituted bodies concerned with licensing of specific categories of health workers and professional practitioners, or the regulatory agencies concerned with evaluating standards or practice. Some situations may warrant the concern and involvement of all such groups. Accurate reporting and factual documentation, and not merely opinion, under gird all such responsible actions. When a nurse chooses to engage in the act of responsible reporting about situations that are perceived as unethical, incompetent, illegal, or impaired, the professional organization has a responsibility to provide the nurse with support and assistance and to protect the practice of those nurses who choose to voice their concerns. Reporting unethical, illegal, incompetent, or impaired practices, even when done appropriately, may present substantial risks to the nurse; nevertheless, such risks do not eliminate the obligation to address serious threats to patient safety.

3.6 **Addressing impaired practice** - Nurses must be vigilant to protect the patient, the public and the profession from potential harm when a colleague's practice, in any setting, appears to be impaired. The nurse extends compassion and caring to colleagues who are in recovery from illness or when illness interferes with job performance. In a situation where a nurse suspects another's practice may be impaired, the nurse's duty is to take action designed both to protect patients and to assure that the impaired individual receives assistance in regaining optimal function. Such action should usually begin with consulting supervisory personnel and may also include confronting the individual in a supportive manner and with the assistance of others or helping the individual to access appropriate resources. Nurses are encouraged to follow guidelines outlined by the profession and policies of the employing organization to assist colleagues whose job performance may be adversely affected by mental or physical illness or by personal circumstances. Nurses in all roles should advocate for colleagues whose job performance may be impaired to ensure that they receive appropriate assistance, treatment and access to fair institutional and legal processes. This includes supporting the return to practice of the individual who has sought assistance and is ready to resume professional duties.

If impaired practice poses a threat or danger to self or others, regardless of whether the individual has sought help, the nurse must take action to report the individual to persons authorized to address the problem. Nurses who advocate for others whose job performance creates a risk for harm should be protected from negative consequences. Advocacy may be a difficult process and the nurse is advised to follow workplace policies. If workplace policies do not exist or are inappropriate--that is, they deny the nurse in question access to due legal process or demand resignation--the reporting nurse may obtain guidance from the professional association, state peer assistance programs, employee assistance program or a similar resource.

Provision 4

The nurse is responsible and accountable for individual nursing practice and determines the appropriate delegation of tasks consistent with the nurse's obligation to provide optimum patient care.

4.1 **Acceptance of accountability and responsibility** – Individual registered nurses bear primary responsibility for the nursing care that their patients receive and are individually accountable for their own practice. Nursing practice includes direct care activities, acts of delegation, and other responsibilities such as teaching, research, and administration. In each instance, the nurse retains accountability and responsibility for the quality of practice and for conformity with standards of care.

Nurses are faced with decisions in the context of the increased complexity and changing patterns in the delivery of health care. As the scope of nursing practice changes, the nurse must exercise judgment in accepting responsibilities, seeking consultation, and assigning activities to others who carry out nursing care. For example, some advanced practice nurses have the authority to issue prescription and treatment orders to be carried out by other nurses. These acts are not acts of delegation. Both the advanced practice nurse issuing the order and the nurse accepting the order are responsible for the judgments made and accountable for the actions taken.

4.2 **Accountability for nursing judgment and action** - Accountability means to be answerable to oneself and others for one's own actions. In order to be accountable, nurses act under a code of ethical conduct that is grounded in the moral principles of fidelity and respect for the dignity, worth, and self-determination of patients. Nurses are accountable for judgments made and actions taken in the course of nursing practice, irrespective of health care organizations' policies or providers' directives.

4.3 **Responsibility for nursing judgment and action** - Responsibility refers to the specific accountability or liability associated with the performance of duties of a particular role. Nurses accept or reject specific role demands based upon their education, knowledge, competence, and extent of experience. Nurses in administration, education, and research also have obligations to the recipients of nursing care. Although nurses in administration, education, and research have relationships with patients that are less direct, in assuming the responsibilities of a particular role, they share responsibility for the care provided by those whom they supervise and instruct. The nurse must not engage in practices prohibited by law or delegate activities to others that are prohibited by the practice acts of other health care providers.

Individual nurses are responsible for assessing their own competence. When the needs of the patient are beyond the qualifications and competencies of the nurse, consultation and collaboration must be sought from qualified nurses, other health professionals, or other appropriate sources. Educational resources should be sought by nurses and provided by institutions to maintain and advance the competence of nurses. Nurse educators act in collaboration with their students to assess the learning needs of the student, the effectiveness of the teaching program, the identification and utilization of appropriate resources, and the support needed for the learning process.

4.4 **Delegation of nursing activities** - Since the nurse is accountable for the quality of nursing care given to patients, nurses are accountable for the assignment of nursing responsibilities to other nurses and the delegation of nursing care activities to other health care workers. While delegation and assignment are used here in a generic moral sense, it is understood that individual states may have a particular legal definition of these terms.

The nurse must make reasonable efforts to assess individual competence when assigning selected components of nursing care to other health care workers. This assessment involves evaluating the knowledge, skills, and experience of the individual to whom the care is assigned, the complexity of the assigned tasks, and the health status of the patient. The nurse is also responsible for monitoring the activities of these individuals and evaluating the quality of the care provided. Nurses may not delegate responsibilities such as assessment and evaluation; they may delegate tasks. The nurse must not knowingly assign or delegate to any member of the nursing team a task for which that person is not prepared or qualified. Employer policies or directives do not relieve the nurse of responsibility for making judgments about the delegation and assignment of nursing care tasks.

Nurses functioning in management or administrative roles have a particular responsibility to provide an environment that supports and facilitates appropriate assignment and delegation. This includes providing appropriate orientation to staff, assisting less experienced nurses in developing necessary skills and competencies, and establishing policies and procedures that protect both the patient and nurse from the inappropriate assignment or delegation of nursing responsibilities, activities, or tasks.

Nurses functioning in educator or preceptor roles may have less direct relationships with patients. However, through assignment of nursing care activities to learners they share responsibility and accountability for the care provided. It is imperative that the knowledge and skills of the learner be sufficient to provide the assigned nursing care and that appropriate supervision be provided to protect both the patient and the learner.

Provision 5

The nurse owes the same duties to self as to others, including the responsibility to preserve integrity and safety, to maintain competence, and to continue personal and professional growth.

5.1 **Moral self-respect** - Moral respect accords moral worth and dignity to all human beings irrespective of their personal attributes or life situation. Such respect extends to oneself as well; the same duties that we owe to others we owe to ourselves. Self-regarding duties refer to a realm of duties that primarily concern one self and include professional growth and maintenance of competence, preservation of wholeness of character, and personal integrity.

5.2 **Professional growth and maintenance of competence** - Though it has consequences for others, maintenance of competence and ongoing professional growth involves the control of one's own conduct in a way that is primarily self-regarding. Competence affects one's self-respect, self-esteem, professional status, and the meaningfulness of work. In all nursing roles, evaluation of one's own performance, coupled with peer review, is a means by which nursing practice can be held to the highest standards. Each nurse is responsible for participating in the development of criteria for evaluation of practice and for using those criteria in peer and self-assessment.

Continual professional growth, particularly in knowledge and skill, requires a commitment to lifelong learning. Such learning includes, but is not limited to, continuing education, networking with professional colleagues, self-study, professional reading, certification, and seeking advanced degrees. Nurses are required to have knowledge relevant to the current scope and standards of nursing practice, changing issues, concerns, controversies, and ethics. Where the care required is outside the competencies of the individual nurse, consultation should be sought or the patient should be referred to others for appropriate care.

5.3 **Wholeness of character** - Nurses have both personal and professional identities that are neither entirely separate, nor entirely merged, but are integrated. In the process of becoming

a professional, the nurse embraces the values of the profession, integrating them with personal values. Duties to self involve an authentic expression of one's own moral point-of-view in practice. Sound ethical decision-making requires the respectful and open exchange of views between and among all individuals with relevant interests. In a community of moral discourse, no one person's view should automatically take precedence over that of another. Thus the nurse has a responsibility to express moral perspectives, even when they differ from those of others, and even when they might not prevail.

This wholeness of character encompasses relationships with patients. In situations where the patient requests a personal opinion from the nurse, the nurse is generally free to express an informed personal opinion as long as this preserves the voluntariness of the patient and maintains appropriate professional and moral boundaries. It is essential to be aware of the potential for undue influence attached to the nurse's professional role. Assisting patients to clarify their own values in reaching informed decisions may be helpful in avoiding unintended persuasion. In situations where nurses' responsibilities include care for those whose personal attributes, condition, lifestyle or situation is stigmatized by the community and are personally unacceptable, the nurse still renders respectful and skilled care.

5.4 **Preservation of integrity** - Integrity is an aspect of wholeness of character and is primarily a self-concern of the individual nurse. An economically constrained health care environment presents the nurse with particularly troubling threats to integrity. Threats to integrity may include a request to deceive a patient, to withhold information, or to falsify records, as well as verbal abuse from patients or coworkers. Threats to integrity also may include an expectation that the nurse will act in a way that is inconsistent with the values or ethics of the profession, or more specifically a request that is in direct violation of the Code of Ethics. Nurses have a duty to remain consistent with both their personal and professional values and to accept compromise only to the degree that it remains an integrity-preserving compromise. An integrity-preserving compromise does not jeopardize the dignity or well-being of the nurse or others. Integrity-preserving compromise can be difficult to achieve, but is more likely to be accomplished in situations where there is an open forum for moral discourse and an atmosphere of mutual respect and regard.

Where nurses are placed in situations of compromise that exceed acceptable moral limits or involve violations of the moral standards of the profession, whether in direct patient care or in any other forms of nursing practice, they may express their conscientious objection to participation. Where a particular treatment, intervention, activity, or practice is morally objectionable to the nurse, whether intrinsically so or because it is inappropriate for the specific patient, or where it may jeopardize both patients and nursing practice, the nurse is justified in refusing to participate on moral grounds. Such grounds exclude personal preference, prejudice, convenience, or arbitrariness. Conscientious objection may not insulate the nurse against formal or informal penalty. The nurse who decides not to take part on the grounds of conscientious objection must communicate this decision in appropriate ways. Whenever possible, such a refusal should be made known in advance and in time for alternate arrangements to be made for patient care. The nurse is obliged to provide for the patient's safety, to avoid patient abandonment, and to withdraw only when assured that alternative sources of nursing care are available to the patient.

Where patterns of institutional behavior or professional practice compromise the integrity of all its nurses, nurses should express their concern or conscientious objection collectively to the appropriate body or committee. In addition, they should express their concern, resist, and seek to bring about a change in those persistent activities or expectations in the practice setting that are morally objectionable to nurses and jeopardize either patient or nurse well-being.

Provision 6

The nurse participates in establishing, maintaining, and improving health care environments and conditions of employment conducive to the provision of quality health care and consistent with the values of the profession through individual and collective action.

6.1 **Influence of the environment on moral virtues and values** – Virtues are habits of character that predispose persons to meet their moral obligations; that is, to do what is right. Excellences are habits of character that predispose a person to do a particular job or task well. Virtues such as wisdom, honesty, and courage are habits or attributes of the morally good person. Excellences such as compassion, patience, and skill are habits of character of the morally good nurse. For the nurse, virtues and excellences are those habits that affirm and promote the values of human dignity, well-being, respect, health, independence, and other values central to nursing. Both virtues and excellences, as aspects of moral character, can be either nurtured by the environment in which the nurse practices or they can be diminished or thwarted. All nurses have a responsibility to create, maintain, and contribute to environments that support the growth of virtues and excellences and enable nurses to fulfill their ethical obligations.

6.2 **Influence of the environment on ethical obligations** - All nurses, regardless of role, have a responsibility to create, maintain, and contribute to environments of practice that support nurses in fulfilling their ethical obligations. Environments of practice include observable features, such as working conditions, and written policies and procedures setting out expectations for nurses, as well as less tangible characteristics such as informal peer norms. Organizational structures, role descriptions, health and safety initiatives, grievance mechanisms, ethics committees, compensation systems, and disciplinary procedures all contribute to environments that can either present barriers or foster ethical practice and professional fulfillment. Environments in which employees are provided fair hearing of grievances, are supported in practicing according to standards of care, and are justly treated allow for the realization of the values of the profession and are consistent with sound nursing practice.

6.3 **Responsibility for the health care environment -** The nurse is responsible for contributing to a moral environment that encourage respectful interactions with colleagues, support of peers, and identification of issues that need to be addressed. Nurse administrators have a particular responsibility to assure that employees are treated fairly and that nurses are involved in decisions related to their practice and working conditions. Acquiescing and accepting unsafe or inappropriate practices, even if the individual does not participate in the specific practice, is equivalent to condoning unsafe practice. Nurses should not remain employed in facilities that routinely violate patient rights or require nurses to severely and repeatedly compromise standards of practice or personal morality.

As with concerns about patient care, nurses should address concerns about the health care environment through appropriate channels. Organizational changes are difficult to accomplish and may require persistent efforts over time. Toward this end, nurses may participate in collective action such as collective bargaining or workplace advocacy, preferably through a professional association such as the state nurses association, in order to address the terms and conditions of employment. Agreements reached through such action must be consistent with the profession's standards of practice, the state law regulating practice and the Code of Ethics for Nursing. Conditions of employment must contribute to the moral environment, the provision of quality patient care and professional satisfaction for nurses.

The professional association also serves as an advocate for the nurse by seeking to secure just compensation and humane working conditions for nurses. To accomplish this, the professional association may engage in collective bargaining on behalf of nurses. While seeking to assure just economic and general welfare for nurses, collective bargaining, nonetheless, seeks to keep the interests of both nurses and patients in balance.

Provision 7

The nurse participates in the advancement of the profession through contributions to practice, education, administration, and knowledge development.

7.1 **Advancing the profession through active involvement in nursing and in health care policy -** Nurses should advance their profession by contributing in some way to the leadership, activities, and the viability of their professional organizations. Nurses can also advance the profession by serving in leadership or mentorship roles or on committees within their places of employment. Nurses who are self-employed can advance the profession by serving as role models for professional integrity. Nurses can also advance the profession through participation in civic activities related to health care or through local, state, national, or international initiatives. Nurse educators have a specific responsibility to enhance students' commitment to professional and civic values. Nurse administrators have a responsibility to foster an employment environment that facilitates nurses' ethical integrity and professionalism, and nurse researchers are responsible for active contribution to the body of knowledge supporting and advancing nursing practice.

7.2 **Advancing the profession by developing, maintaining, and implementing professional standards in clinical, administrative, and educational practice** - Standards and guidelines reflect the practice of nursing grounded in ethical commitments and a body of knowledge. Professional standards and guidelines for nurses must be developed by nurses and reflect nursing's responsibility to society. It is the responsibility of nurses to identify their own scope of practice as permitted by professional practice standards and guidelines, by state and federal laws, by relevant societal values, and by the Code of Ethics.

The nurse as administrator or manager must establish, maintain, and promote conditions of employment that enable nurses within that organization or community setting to practice in accord with accepted standards of nursing practice and provide a nursing and health care work environment that meets the standards and guidelines of nursing practice. Professional autonomy and self regulation in the control of conditions of practice are necessary for implementing nursing standards and guidelines and assuring quality care for those whom nursing serves.

The nurse educator is responsible for promoting and maintaining optimum standards of both nursing education and of nursing practice in any settings where planned learning activities occur. Nurse educators must also ensure that only those students who possess the knowledge, skills, and competencies that are essential to nursing graduate from their nursing programs.

7.3 **Advancing the profession through knowledge development, dissemination, and application to practice** - The nursing profession should engage in scholarly inquiry to identify, evaluate, refine, and expand the body of knowledge that forms the foundation of its discipline and practice. In addition, nursing knowledge is derived from the sciences and from the humanities. Ongoing scholarly activities are essential to fulfilling a profession's obligations to society. All nurses working alone or in collaboration with others can participate in the advancement of the profession through the development, evaluation, dissemination, and application of knowledge in practice. However, an organizational climate and infrastructure conducive to scholarly inquiry must be valued and implemented for this to occur.

Provision 8

The nurse collaborates with other health professionals and the public in promoting community, national, and international efforts to meet health needs.

8.1 **Health needs and concerns** - The nursing profession is committed to promoting the health, welfare, and safety of all people. The nurse has a responsibility to be aware not only of specific health needs of individual patients but also of broader health concerns such as world hunger, environmental pollution, lack of access to health care, violation of human rights, and inequitable distribution of nursing and health care resources. The availability and accessibility of high quality health services to all people require both interdisciplinary planning and collaborative partnerships among health professionals and others at the community, national, and international levels.

8.2 **Responsibilities to the public** - Nurses, individually and collectively, have a responsibility to be knowledgeable about the health status of the community and existing threats to health and safety. Through support of and participation in community organizations and groups, the nurse assists in efforts to educate the public, facilitates informed choice, identifies conditions and circumstances that contribute to illness, injury and disease, fosters healthy life styles, and participates in institutional and legislative efforts to promote health and meet national health objectives. In addition, the nurse supports initiatives to address barriers to health, such as poverty, homelessness, unsafe living conditions, abuse and violence, and lack of access to health services.

The nurse also recognizes that health care is provided to culturally diverse populations in this country and in all parts of the world. In providing care, the nurse should avoid imposition of the nurse's own cultural values upon others. The nurse should affirm human dignity and show respect for the values and practices associated with different cultures and use approaches to care that reflect awareness and sensitivity.

Provision 9

The profession of nursing, as represented by associations and their members, is responsible for articulating nursing values, for maintaining the integrity of the profession and its practice, and for shaping social policy.

9.1 **Assertion of values** - It is the responsibility of a professional association to communicate and affirm the values of the profession to its members. It is essential that the professional organization encourages discourse that supports critical self-reflection and evaluation within the profession. The organization also communicates to the public the values that nursing considers central to social change that will enhance health.

9.2 **The profession carries out its collective responsibility through professional associations** - The nursing profession continues to develop ways to clarify nursing's accountability to society. The contract between the profession and society is made explicit through such mechanisms as

(a) The Code of Ethics for Nurses
(b) the standards of nursing practice
(c) the ongoing development of nursing knowledge derived from nursing theory, scholarship, and research in order to guide nursing action
(d) educational requirements for practice
(e) certification, and
(f) mechanisms for evaluating the effectiveness of professional nursing actions.

9.3 **Intra-professional integrity** - A professional association is responsible for expressing the values and ethics of the profession and also for encouraging the professional organization and its members to function in accord with those values and ethics. Thus, one of its fundamental responsibilities is to promote awareness of and adherence to the Code of Ethics and to critique the activities and ends of the professional association itself. Values and ethics influence the power structures of the association in guiding, correcting, and directing its activities. Legitimate concerns for the self-interest of the association and the profession are balanced by a commitment to the social goods that are sought. Through critical self-reflection and self-evaluation, associations must foster change within themselves, seeking to move the professional community toward its stated ideals.

9.4 **Social reform** - Nurses can work individually as citizens or collectively through political action to bring about social change. It is the responsibility of a professional nursing association to speak for nurses collectively in shaping and reshaping health care within our nation, specifically in areas of health care policy and legislation that affect accessibility, quality, and the cost of health care. Here, the professional association maintains vigilance and takes action to influence legislators, reimbursement agencies, nursing organizations, and other health professions. In these activities, health is understood as being broader than delivery and reimbursement systems, but extending to health-related socio-cultural issues such as violation of human rights, homelessness, hunger, violence, and the stigma of illness.

Public Health Nursing Practice

(Excerpts from "The tenets of public health nursing by the Quad Council of Public Health Nursing Organizations", Josten, LaBohn, PhD, RN, 1997.)

The Tenets of Public Health Nursing include:

The process of population-based assessment, policy development and assurance is systematic and comprehensive. This process includes consideration of all of the determinants of health (social, economic, and physical environmental, personal/lifestyle health practices, human biology, community capacity, and health services) as they affect the population's health (Federal, Provincial and Territorial Advisory Committee of Population Health, 1994). The process includes assessment of the needs, strengths and expectations of all the people guided by epidemiological methods. Policies are developed with a view toward the priorities set by the people with consideration of effectiveness of intervention and program options on influencing the health goals of the people. Assurance strategies that carry out developed policies include interventions and programs delivered by both public health nurses and other health care professionals or organizations aimed at assuring the availability and access of needed services. Data collected systematically from individuals receiving community-based nursing services can be a method of obtaining information on the people's meaning of the health experience. However, data from assessment of individuals and families may be aggregated to the whole population only when biostatistical approaches are used to determine if the individuals/families are truly representatives of the whole.

In all processes partnerships with representatives of the people are essential. Facilitation of the inclusion of the people's meaning or perspectives is stressed so that their perspective are reflected in interpretation of the data, policy decisions and planning programs. This is necessary so policies and programs can be oriented by the priorities and values of the people. This can be achieved by having the people elect representatives to work in partnership with the public health nurse. Representatives of multiple communities is emphasized so that decisions are made with consideration of what is in the best interest of all of the people, not just those in one community.

Primary prevention is given priority. The practice places emphasis on primary prevention in all of its processes (assessment, policy development and assurance). Primary prevention includes health promotion and health protection strategies.

Creating health environmental social, and economic conditions in which people live guides selection of intervention strategies. The practice is to intervene to eliminate harmful social, physical or economic environment conditions and to create conditions that support leading healthy lives. It also involves changing the system of care so it promotes the peoples' health. Although all nurses are concerned about the environment in which their individual clients live, public health nurses concentrate on interventions aimed at improving those environments to benefit the health of the whole population. Interventions include educational, community development, social engineering, and policy development and enforcement strategies. Interventions tend to emerge from the political or community participation process resulting in governmental policies and laws, administrative rules and budget processes or to emerge from policy and resource control mechanisms within public or private organizations. Some interventions will support functions and systems that promote health while others will protect the health of the people by prohibiting harmful practices.

The practice incorporates an obligation to actively reach out to all who might benefit from an intervention or service. Often, those most likely to benefit are those who are the most marginal to the benefits of society. Provision of services only to those who present themselves for services is not public health nursing without actions to gain participation of the entire population who might benefit from that service.

The dominant concern is for the greater good of all the people or the population as a whole. Public Health Nurses also carry with them an obligation to promote the health needs of each individual. This is done with recognition that it may not be possible to meet all identified individual needs when they are in conflict with other priority health goals that benefit the whole population.

The wise stewardship and allocation of the available resources is supported in order to gain the maximum population health benefit from the use of those resources. This includes providing members of the population and leaders with information they need so that available resources can be used to attain the best overall improvement in the health of the entire population. Information should include scientific data on potential outcomes of various policy decisions as well as where possible, the cost benefit or cost effectiveness of the multiple potential intervention strategies.

The health of the people is not effectively promoted and protected through collaboration with members of other professions and organizations. Creating conditions in which people can be healthy is an extremely complex, resource intense process. Public health nurses facilitate inclusion of the expertise of members of multiple professions and organizations in efforts to improve population health.

Processes include:

- Promoting systems that provide populations with access to and high quality individual nursing care. Public Health Nursing practice includes providing leadership to assure that all of the people have their individual nursing needs met. This includes collaborating with other nurses in developing public policies that assure an adequate supply of well prepared nurses to work in all earth settings, developing and enforcing public and organizational policies which assure access to quality nursing services, and supporting nursing research and evaluation so that the quality of care by all nurses is promoted.

- Providing or assuring care to individual families in the community (community-based care) when their health condition creates a risk to the health of the population. The decision to provide community-based care is based on its contribution to improvement of the health of the whole population, and emerges out of a population-based process of assessment, policy development and assurance. Community-based care is a public health nursing strategy when it directly benefits the whole population by reducing their exposure to risk factors.

Public Health Nursing in a Reformed Health Care System

The public health nursing community believes a strong public health system must have population-focused health care and primary care services. The role of public health nursing includes the core functions of public health: assessment, policy development, and assurance, as well as health education and evaluation.

A strong public health structure must have:

Appropriations specific for local/community needs instead of or in addition to block granting;

Delivery of an essential package of public health care services available and accessible to all individuals;

Funding for public health nursing services to provide population-focused care and primary care.

In those instances where primary care services are not readily accessible or available in a privatized setting, assurance means that primary care services need to be provided by public health nurses. Public health nurses function as case managers for those who under-utilize services. Their cost effective outreach, intervention, and care coordination efforts result in disease prevention and health promotion.

Public health nurses, within a primary care practice, empower individuals and families. By doing physical assessment, including early childhood screening, these nurses enable their clients to use primary care centers, immunization programs, and community agencies. Health outcome indices of public health nursing interventions include reductions in family violence, poor pregnancy outcomes, communicable disease, morbidity and premature mortality.

Public health nurses, with their broad-based knowledge and experience, can reduce health care costs through early detection and prevention of health problems, thus reducing the need for costly tertiary care.

Population Focused Practice

The goal of population-focused practice is to promote health communities. Public health nurses bring expertise to the collaborative, interdisciplinary process of assessment, policy development, and assurance activities to promote healthy outcomes in a community.

Competencies of the public health nurse include:

1. Community assessment of health risk factors and disease indicators:

   Public health nurses:

   - Evaluate demographic, epidemiologic, and biostatistical data to anticipate and identify risks and patterns of morbidity and mortality.
   - Evaluate changing health behaviors and patterns that have the potential to place people at risk.
   - Determine other indicators to monitor the dimensions of health status valued by the community.

2. Policy development to reduce health problems:

   Public health nurses:

   - Analyze assessment data to identify potential and actual health problems.

- Work to develop partnerships and strategies to address identified health problems.

- Participate in health policy development as advocated for the needs of children, families, groups, and communities.

3. Assurance activities to promote the effective implementation of policy at the service delivery level:

   Public health nurses:

   - Assure appropriate service delivery to achieve targeted health care outcomes.

   - Monitor health service access, utilization and appropriateness for the community, including underserved and target populations.

   - Participate in developing systems and programs to promote positive health outcomes for the community.

   - Work to implement continuous quality improvement for health care systems in the community.

   - Provide expert public health nurse consultation to groups and organizations in the community.

Primary Care for Targeted Populations

The goal of the public health component of primary care enables individuals to assume responsibility for their own health as members of the community. This care occurs at worksites, schools, homes, farms, barrios, shelters and correctional facilities. The public health nurse role is to assess needs of individuals and families, provide nursing services including health education and to continually evaluate individuals and families' health status.

The following are some of the primary care services provided by public health nurses.

Public health nurses:

- Immunize children and conduct well child care clinics.
- Deliver therapy to individuals with tuberculosis and AIDS.
- Conduct pre-natal clinics and home visits to improve pregnancy outcomes.
- Deliver home based services to families.
- Conduct migrant, rural, and school-based health clinics.
- Manage the continuum of care to assure that individuals receive timely, cost effective and quality health care services.

<u>It is essential that funding for public health nursing is a component of any public health legislation and that funding levels be sufficient for supporting the above outlined roles and activities.</u>

Reference

The Quad Council (Association of State and Territorial Directors of Nursing; Association of Community Health Nursing Educators; American Public Health Association, Section of Public Health Nursing; American Nurses Association, Council of Community, Primary and Long Term care). (Statement revised 1993 and reaffirmed 1997).

Nursing Competencies Based on Essential Services

http://www.naccho.org

CORE Competences

Public Health Foundation

http://www.trainingfinder.org/competencies

Professional Growth

The professional growth of the public health nurse is a dynamic, continuous process necessitated by the magnitude of new information. To provide "state of the art" nursing care, the nurse must be knowledgeable of new techniques and theories on a continuing basis because what was current yesterday may be obsolete today. The public health nurse is expected to perform many functions beyond providing quality nursing care such as collaborating with community agencies and elected officials, and participating in legislative movements. Therefore, the American Nurses' Association and American Public Health Association both recommend the bachelor's degree as the beginning preparation for the nurse in public health practice.

Continuing professional growth is the responsibility of every nurse. For the nurse who has not attained a Bachelor's degree, it is recommended that an educational plan be established with a college of choice. Continuing education programs are offered across the state to provide current information and skills needed by the progressive practitioner.

Membership and active participation in the professional nursing and public health organizations are encouraged to further the development of the nurse and the nursing community. Active membership in the Kansas Public Health Association and Kansas Association of Local Health Departments also provides opportunities for professional growth. Continuing education provides the foundation for the practice of the creative, adaptable public health nurse.

The numerous responsibilities the public health nurse fulfills in a variety of settings necessitate independent nursing judgment and accountability. As a measure of risk management, each nurse is encouraged to carry adequate professional liability insurance. Liability insurance may be purchased from the American Nurses Association, other nurse organizations, and commercial insurance companies.

RN to BSN Completion

Ten colleges and universities offer the associate degree or diploma prepared nurse an opportunity for professional growth through degree completion courses. A bachelor's degree gives a nurse the accepted entry-level preparation as a professional public health nurse. It also serves as a base for career development and understanding population based nursing.

While all of these schools have slightly different admission and course requirements, they have many features in common. These include state and N.L.N. accreditation, a means to give credit for past nursing education and experience, course work in community and public health, and accommodation for part time students. Other features offered by some of the schools are off site classes, accelerated degree completion, Masters programs, and R.N. to Masters programs.

The following is a list of these schools of nursing and how to contact them:

Baker University
School of Nursing
Pozez Education Center
1500 W. 10th St.
Topeka, KS 66604
785-354-5850
Web Site: http://www.universities.com/Schools/B/Baker_University_School_Of_Nursing.asp

Emporia State University
Department of Nursing
1127 Chestnut

Emporia, KS 66801
620-343-6800 ext. 5641
Web site: http://www.emporia.edu/ndn/clinsite.htm

Fort Hays State University
Department of Nursing
Stroup Hall 120
600 Park St.
Hays, KS 67202-3802
1-800-684-2242
Web site: http://www.fhsu.edu/nursing

Newman University (fka Kansas Newman College)
Division of Nursing
3100 McCormick
Wichita, KS 67213
1-877-639-6268
Web site: http://www.newmanu.edu/Degrees/BS/bsnursing.pdf

Kansas Wesleyan University
Division of Nursing Education
100 East Claflin Ave.
Salina, KS 67401
1-800-874-1154 ext. 7220
Web site: http://www.kwu.edu/nursing

Mid America Nazarene University
Division of Nursing
2030 E. College Way
Olathe, KS 66062-1899
913-782-3750 or 1800-800-8887
Web site: http://www.mnu.edu/nursing

Pittsburg State University
Department of Nursing
1701 S. Broadway
Pittsburg, KS 66762-5885
620-231-7000
Web site: http://www.pittstate.edu/nurs

Southwestern College
Nursing Department
100 College Street
Winfield, KS 67156
620-229-6207
Web site: http://www.universities.com/Schools/S/Southwestern_College_KS.asp

University of Kansas
School of Nursing
Office of Student Affairs
3901 Rainbow Blvd.
Kansas City, KS 66160-7501
913-588-1619

Web site: http://www2.kumc.edu/son

Washburn University
School of Nursing
1700 SW College Ave.
Topeka, KS 66621
(785) 231-1010 ext. 1533 or ext. 1525
Web site: http://www.washburn.edu/sonu

Wichita State University
School of Nursing
1845 Fairmount
Wichita, KS 67260-0041
1-800-516-0290
Web site: http://webs.wichita.edu/depttools/user_home/?view=chp_nurs&page=nursinghomepage

Cultural Competency

In order to enable minorities to enjoy equal opportunity and remain health, active, and independent, it is essential to use approaches and interventions that respect cultural values and beliefs and appropriately address their needs.

Growing Diverse Populations

The United States is a nation with a rich mix of persons with diverse racial, ethnic, and cultural background. The minority population will increase tremendously in the coming years.

Barriers to Access

Health and other disparities that separate racial and ethnic minorities are due, in part, to problems experienced in accessing and using health and human services. One reason for this may be that service systems are not responsive to the needs of minority clients. Often services are not "**culturally sensitive.**" Barriers may include:

- language
- lack of appropriate information
- distrust of the mainstream delivery system
- low income
- low education levels

Cultural Competency Defined

Cultural competency is a set of behaviors and attitudes integrated into the practices and policies of agencies or professional service providers that enables them to understand and work effectively in cross-cultural situations. Translating and integrating knowledge about individuals and groups of people into specific practices and policies applied in appropriate cultural settings can achieve cultural competence. When professionals are culturally competent, they establish positive helping relationships that engage the client and improve the quality of services they provide.

Characteristics of Culturally Competent Service Delivery

- **Cultural appropriateness** – being sensitive to the cultural norms, values, and beliefs of the particular individual, the situation, and the environment as they pertain to the needs of the ethnic client and the types of services to be utilized.

- **Cultural access** – providing information and services in languages or through media that facilitates delivery to the minority client.

- **Cultural acceptability** – encouraging the ethnic client to actively seek services.

Creating Culturally Competent Programs that Work

In a society as diverse as the United States, health and social service providers and others who deliver services must be able to relate to and communicate with diverse clientele. They need to be aware of culturally influenced behaviors. Five essential elements that contribute to an organization's ability to become more culturally competent include:

1. **Valuing diversity**: Organizations must value diversity in order to establish the policies and procedures needed to become culturally competent.

2. **Having the capacity for cultural self-assessment**: Organizations must establish and understand their own identity in order to develop and implement goals.

3. **Being conscious of the dynamics inherent when cultures interact**: How and where the services are provided are critical to service delivery.

4. **Having institutionalized cultural knowledge**: All levels of the organization must be culturally aware.

5. **Adapting service delivery based on understanding of cultural diversity**: Programs and services must be delivered in a way that reflects the culture and traditions of the people served.

Department of Health & Human Services - Administration on Aging
http://www.aoa.gov/prof/adddiv/cultural/addiv_cult.asp

The Clinical Center & Education Training
http://ohrm.cc.nih.gov/train/competency/corecomp.html

Agency for Healthcare Research and Quality
http://www.ahrq.gov/research

LEP Template for Local Health Departments

INTRODUCTION

In order for the _____ Health Department to comply with Title VI of the Civil Rights Act of 1964, this policy guidance is in place to prevent discrimination of persons with Limited English Proficiency (LEP). LEP describes individuals who cannot speak, read, write or understand the English language at a level that permits them to interact effectively with health care provider and social service agencies.

APPLICATION

All public and private entities receiving Department of Health and Human Services federal financial assistance are "covered entities." Title VI of the Civil Rights Act of 1964 prohibits discrimination by federally funded entities based on race, color and nation origin.

BACKGROUND

The four keys to Title VI compliance in the LEP context are:

- *Assessment* - The recipient/covered entity conducts a thorough assessment of the language needs of the population to be served. * See attachment "A"
- *Development of Comprehensive Written Policy on Language Access* – The recipient/covered entity develops and implements a comprehensive written policy that will ensure meaningful communication
- *Training of Staff* - The recipient/covered entity takes steps to ensure that staff understands the policy and is capable of carrying it out.
- *Vigilant Monitoring* - The recipient/covered entity conducts regular oversight of the language assistance program to ensure that LEP persons receive meaningfully access the program.

OCR will consider a recipient/covered entity to be in compliance with its Title VI obligation to provide written materials in non-English languages if:

A. All written materials are translated for each LEP group of 10% or 3,000 (whichever is less) of the eligible population.
B. Vital documents are translated for each LEP group of 5% or 1,000 (whichever is less) of the eligible population.
C. For each language group with fewer than 100 persons, the entity provides written notice of the right to receive oral interpretation of written materials in the primary language of the group.

I. NEEDS ASSESSMENT

_____ Health Department has assessed the size of its covered entity. The geographic area we serve is _____. Currently there is a total eligible population of _____ people needing language assistance who are eligible for services at the _____ Health Department.

** To identify language groups in your geographic area look at http://factfinder.census.gov (under Table DP2 - Profile of Selected Social Characteristics: 2000). FYI - a sample is included of Jackson County, Missouri.

_____ Health Department provides the following programs and service: _____

_____
_____
_____
_____.

There are currently _____ people meeting the program eligibility guidelines who have a primary language other than English. Of those persons _____# are not literate in their primary language. The identified language needs of individuals served in _____ Health Department are (check which ones apply)

___ Oral ___ Translation

II. POLICY re: LANGUAGE ACCESS

** This section (II. Policy re: Language Access) is to be completed by those entities falling in category 'A" and/or "B" above. If your covered entity falls under "C" above, this section *only* doesn't apply to you.

Upon enrollment for services the _____ Health Department will define and describe the location(s) where the client needs language assistance. (Use Encounter Record form to record persons with Limited English Proficiency.) Copy enclosed (Form #1).

List program(s) for which documents are printed in different languages (if this applies to your county/covered entity).

Document #1 _____
Document #2 _____
Document #3 _____
Document #4 _____
Document #5 _____

Define the types of assistance that are available at the _____ Health Department.
____ Oral ____ Translation

III. STAFF TRAINING

There are _____ bilingual persons on staff. They have been trained and are competent. List the training sessions each bilingual staff member has attended and the dates. (See employee training information sheet - Form #2)

List the volunteer interpreters that are used to aid in language assistance. List their training and skills.

_____
_____
_____
_____

Recipient/covered entity must ensure that these volunteers are competent as interpreters and understand their obligation to maintain client confidentiality. (Design a volunteer training information sheet). Describe what is expected of your volunteer interpreter staff.

List all contracts your local health department has with another agency, university, hospital, etc. for interpreter or translation services and describe their exact duties. *Such contract interpreters must be readily available and competent. (Attach copy of contract)*

_____
_____

_____

_____

List all Telephone Interpreter (TI) services you have in place for those hard to find languages.

_____

_____

Make sure staff members are familiar with using TI services. (Attach TI contract if applicable) See attached Form #3 "Materials to be Translated".
See Attachment "B" for TI services.

Translations of Written Materials - The _____ Health Department will ensure that written materials that are routinely provided in English to applicants, clients and the public are available in regularly encountered languages other than English (vital documents, applications, consent/authorization forms, letters containing important information regarding participation in a particular program (Medicaid, etc.).

IV. MONITORING

Health department will monitor its language assistance program at least annually:

* To assess the current LEP makeup of its service area
* To assess the current communication needs of LEP applicants and clients
* (See Monitoring of Program Effectiveness information sheet - Form #4)

Assistance to the LEP persons will be in a timely manner, so services won't be delayed. These services will be provided at *no* cost to the LEP person (s).

The _____ Health Department will discourage applicants/clients from using family members, minor children or friends to serve as interpreters. Use of such persons could result in a breach of confidentiality or reluctance on the part of individuals to reveal personal information critical to their situations. In a medical setting, this reluctance could have serious, even life threatening, consequences. In addition, family and friends usually are not trained to act as interpreters, since they are often insufficiently proficient in both languages, unskilled in interpretation, and unfamiliar with specialized terminology.

* Special thanks to those who worked on forms, contents, proof reading, etc.
Susan Morris - KDHE
Nancy Jorn, RN - Lawrence-Douglas County Health Department
Tina Ferguson - Lawrence-Douglas County Health Department
LEP Task Force (KDHE staff and Local Health Departments)
KDHE Public Health Nurse Specialists

November 2002

Public Health Nursing Policies

The local health department should have written policies and procedures for all programs to serve as a guide and standard to be used in making judgments and decisions regarding client care. As a licensed practitioner, the nurse is accountable for his or her nursing practice and for the quality of nursing care delivered.

Client care guidelines should be developed for each service offered, i.e. immunizations, maternal-infant, family planning, child health conference, child assessment, early intervention screening and education, W.I.C., prenatal risk reduction, newborn home visits, high risk infant care, healthy start, healthy families, communicable disease, infection control, home health, etc.

Referrals

Clients may be referred to the public health nurse from an agency or institution, another health professional, family or interested person, or as a self-referral. Upon receipt of a referral, the public health nurse should assess the client's needs, determine needed action, and provide nursing care. If medical care is indicated, referral to a physician or other appropriate health care provider should be made. In many cases, collaborative care is appropriate and the nurse and the other health care provider are both engaged to meet the client's health care needs. Written referrals provide a permanent record of the case referred. Referral forms provide pertinent information and feedback.

Medical Orders

There should be a written policy within the agency signed and approved by the medical consultant to assure that telephone orders are managed properly. Such policy should specify that orders may only be received from and given to a physician or licensed professional nurse. The policy should specify the method and time frame to obtain written confirmation and the action required if written confirmation is not obtained. A confirmed order should then be attached to the client's chart.

Standing orders are appropriately used in a health department for some services (e.g. immunizations, anaphylaxis, STD, or family planning). When standing orders are utilized, they should be reviewed or revised and signed annually by the responsible physician. Re-signing is necessary whenever there is a physician change, retain replaced, signed orders in accordance with agency record-retention policy.

When the nurse is working in collaboration with the physician on cases such as home care, the medical orders must be received and renewed according to written agency policy.

Emergency Treatment

Written, standing orders should be established and signed by the physician responsible for emergency care and be posted in treatment areas. These orders should be reviewed and signed each year by the physician. It is recommended that all health department personnel maintain current CPR certification. Records should be maintained confirming timely review and checking of emergency orders, procedures, equipment, drugs and dosages by the nursing staff. It may be advisable to assign this responsibility to one nurse.

Drawing Blood

Registered nurses may draw blood from a client with a written order from a physician for a specific client or by written policy for a clinic or program (e.g., family planning, communicable disease control).

Client Transportation

It is strongly recommended that the public health nurse not transport clients. If required by the governing body there should be written policies regarding legal responsibilities as well as adequate insurance provided by the employer.

Delegation

American Nurses Association Position Statement

Registered Nurse Utilization of Unlicensed Assistive Personnel

Summary: The American Nurses Association (ANA) recognizes that unlicensed assistive personnel provide support services to the RN, which is required for the registered nurse to provide nursing care in the health care settings of today.

The current changes in the health care environment have and will continue to alter the scope of nursing practice and its relationship to the activities delegated to unlicensed assistive personnel (UAP). The concern is that in virtually all health care settings, UAP's are inappropriately performing functions that are within the legal practice of nursing. This is a violation of the state nursing practice act and is a threat to public safety. Today, it is the nurse who must have a clear definition of what constitutes the scope of practice with the reconfiguration of practice settings, delivery sites and staff composition. Professional guidelines must be established to support the nurse in working effectively and collaboratively with other health care professionals and administrators in developing appropriate roles, job descriptions and responsibilities for UAP's.

The purpose of this position statement is to delineate ANA's beliefs about the utilization of unlicensed assistive personnel in assisting in the provision of direct and indirect patient care under the direction of a registered nurse.

Unlicensed Assistive Personnel

The term unlicensed assistive personnel applies to an unlicensed individual who is trained to function in an assistive role to the licensed nurse in the provision of patient/client activities as delegated by the nurse. The activities can generally be categorized as either direct or indirect care.

Direct patient care activities are delegated by the registered nurse and assist the patient/client in meeting basic human needs. This includes activities related to feeding, drinking, positioning, ambulating, grooming, toileting, dressing and socializing and may involve the collecting, reporting and documentation of data related to these activities.

Indirect patient care activities focus on maintaining the environment and the systems in which nursing care is delivered and only incidentally involve direct patient contact. These activities assist in providing a clean, efficient, and safe patient care environment and typically encompass categories such as housekeeping and transporting, clerical, stocking, and maintenance supplies.

Utilization

Monitoring the regulation, education and utilization of unlicensed assistive personnel to the registered nurse has been ongoing since the early 1950's. While the time frames and environmental factors that influence policy may have changed, the underlying principles have remained consistent:

- IT IS THE NURSING PROFESSION that determines the scope of nursing practice;
- IT IS THE NURSING PROFESSION that defines and supervises the education, training and utilization for any unlicensed assistant roles involved in providing direct patient care;
- IT IS THE RN who is responsible and accountable for the provision of nursing practice;
- IT IS THE RN who supervises and determines the appropriate utilization of any unlicensed assistant involved in providing direct patient care; and
- IT IS THE PURPOSE of unlicensed assistive personnel to enable the professional nurse to provide nursing care for the patient.

It is the assumption of the ANA that the provision of safe, accessible and affordable nursing care for the public may include the appropriate utilization of unlicensed assistive personnel and that the changes in the health care environment have and will continue to alter the activities delegated to UAP's.

Therefore, it is the responsibility of the nursing profession to establish and the individual nurse to implement the standards for the practice and utilization of unlicensed assistive personnel involved in assisting the nurse in the direct patient care activities. This is accomplished through national standards of practice and the definitions of nursing in state nursing practice acts.

In order to understand the roles and responsibilities between the RN and the UAP the ANA recognizes that the key to understanding is the clarification of professional nursing care delivery and the activities that can be delegated within the domain of nursing. The act of delegation is: the transfer of responsibility for the performance of an activity from one person to another while retaining accountability for the outcome.

In delegating, it is the RN who uses professional judgment to determine the appropriate activities to delegate. The determination is based on the concept of protection of the public and includes consideration of the needs of the patients, the education and training of the nursing and assistive staff, the extent of supervision required, and the staff workload. Any nursing intervention that requires independent, specialized, nursing knowledge, skill or judgment cannot be delegated.

References

American Nurses Association (1995). The ANA Basic Guides to Safe Delegation. Item #BGSD.

Kansas Nurse Practice Act. K.S.A. 65-1113 et seq.; KAR 60-15-101 et seq. Also see this manual.

Pharmacy Regulations Pertinent to Public Health Departments

Several public health department services involve storing and dispensing of pharmaceutical products. These activities are controlled in Kansas by State Statute K.S.A. 65-1648 and administrative regulation KAR 68-7-18.

K.S.A. 65-1648.
Medical care facilities; distribution and control of prescription medications; adult care homes, maintenance and use of emergency medication kit; health departments; rules and regulations.

(a) Any medical care facility pharmacy registered by the board may keep drugs in such facility and may supply drugs to its inpatients and outpatients. Distribution and control of prescription medications in a medical care facility pharmacy shall be under the supervision of a pharmacist in charge. A designated registered nurse or nurses or a licensed physician assistant approved by the pharmacist in charge and under the supervision of the pharmacist in charge shall be in charge of the distribution and control of drugs of a medical care facility pharmacy when a pharmacist is not on the premises. Drugs supplied to outpatients when a pharmacist is not on the premises shall be limited to the quantity necessary until a prescription can be filled.

(b) Nothing contained in this act shall be construed as prohibiting an adult care home which utilizes the services of a pharmacist, from maintaining an emergency medication kit approved by the adult care home's medical staff composed of a duly licensed practitioner and a pharmacist. The emergency medication kit shall be used only in emergency cases under the supervision and direction of a duly licensed practitioner, and a pharmacist shall have supervisory responsibility of maintaining said emergency medication kit.

(c) Every adult care home which maintains an emergency medication kit under subsection (b) shall comply with the following requirements:

(1) Drugs in an emergency medication kit shall be maintained under the control of the pharmacist in charge of the pharmacy from which the kit came until administered to the patient upon the proper order of a practitioner.

(2) Drugs contained within the emergency medication kit may include controlled substances, but in such case a pharmaceutical services committee shall be responsible for specifically limiting the type and quantity of controlled substance to be placed in each emergency kit.

(3) Administration of controlled substances contained within the emergency medication kit shall be in compliance with the provisions of the uniform controlled substances act.

(4) The consultant pharmacist of the adult care home shall be responsible for developing procedures, proper control and accountability for the emergency medication kit and shall maintain complete and accurate records of the controlled substances, if any, placed in the emergency kit. Periodic physical inventory of the kit shall be required.

(d) (1) The Kansas State Department of Health and Environment, any county, city-county or multi-county health department, indigent health care clinic, federally qualified health center and any private not-for-profit family planning clinic, when registered by the board, may keep drugs for the purpose of distributing drugs to patients being treated by that health department, indigent health care clinic, federally qualified health center or family planning clinic. Distribution and control of prescription medications in a health department, indigent health care clinic, federally qualified health center or family planning clinic shall be under the supervision of a pharmacist in charge. A designated registered nurse or nurses or a licensed physician assistant approved

by the pharmacist in charge shall be in charge of distribution and control of drugs in the health department, indigent health care clinic, federally qualified health center or family planning clinic under the supervision of the pharmacist in charge when a pharmacist is not on the premises. Drugs supplied to patients when a pharmacist is not on the premises shall be limited to the quantity necessary to complete a course of treatment as ordered by the practitioner supervising such treatment.

(2) The board shall adopt rules and regulations relating to specific drugs to be used, to record keeping and to storage of drugs by a health department, indigent health care clinic, federally qualified health center or family planning clinic as are necessary for proper control of drugs.

KAR 68-7-18
Health departments and private not-for-profit family planning clinics.

The distribution and control of drugs provided by health departments and private not-for-profit family planning clinics authorized under K.S.A. 65-1648(d)(1), and amendments thereto, shall conform to the following requirements:

(A) The approved drugs that may be stored and distributed by health departments and not-for-profit family planning clinics shall be only noncontrolled drugs that are approved by the food and drug administration. In determining the formulary for each health department or not-for-profit family planning clinic, the pharmacist-in-charge shall consult with the medical supervisor and director of nursing for that facility. No state or federal controlled drugs shall be allowed.

(B)

(1) The pharmacist-in-charge shall review the procedures outlined below for the distribution and control of all drugs within health department facilities and family planning clinics and shall be responsible for the following:

(a) Ensuring the development of programs for supervision of all personnel in the distribution and control of drugs;

(b) ensuring the development of a policy and procedure manual governing the storage, control, and distribution of drugs;

(c) maintaining documentation of at least quarterly checks of drug records, drug storage conditions, and drugs stored in all locations within the facility;

(d) establishing a drug recall procedure that can be effectively implemented; and

(e) ensuring the development of written procedures for maintaining records of distribution and prepackaging of drugs.

(2) Labels for prepackaged drugs shall contain the following:

(a) The brand name or corresponding generic name of the drug;

(b) the name of the manufacturer or distributor of the drug , or an easily identified abbreviation of the manufacturer's or distributor's name; the strength of the drug;

(c) the strength of the drug;

(d) the contents in terms of weight, measure, or numerical count;

(e) the lot number of the drug, if the lot number is not recorded on a suitable log; and

(f) the beyond-use date of the drug.

(3) Prepackaged drugs shall be packaged in suitable containers and shall be subject to all other provisions of the Kansas State Board of Pharmacy regulations under the uniform controlled substances act of the state of Kansas and under the Pharmacy Act of the State of Kansas.

(C) The procedures for the control and distribution of drugs within health department facilities and family planning clinics shall be consistent with the following requirements:

(1) Adequate records of the distribution of drugs by the designated registered professional nurse or nurses shall be maintained and shall include the physician's order or written protocol.

(a) If the physician's order was given orally, electronically, or by telephone, the designated registered professional nurse or nurses shall reduce that order to writing. The written copy of the order shall be signed by the designated registered professional nurse and maintained in a permanent patient file.

(b) The records shall include the following:

(i) The full name of the patient;

(ii) the date supplied;

(iii) the name of the drug, the quantity supplied, and strength of the drug distributed;

(iv) the directions for use;

(v) the prescriber’s name. The record shall include the name of the practitioner and, if involved, the name of either the physician’s assistant (PA) or the advanced registered nurse practitioner (ARNP);

(vi) the expiration date of the drug; and

(vii) the lot number of the drug.

(2) A supply of drugs shall be provided to a patient by a designated registered professional nurse or nurses pursuant to a prescriber's order. Only a designated registered professional nurse or nurses may access the pharmacy area and remove the supply of the drugs. The supply shall conform to the following labeling requirements:

(a) the name, address, and telephone number of the health department or family-planning clinic from which the drug is supplied;

(b) the full name of the patient;

(c) adequate directions for use of the drug;

(d) the name of the prescriber. The label shall include the name of the practitioner and, if involved, the name of either the physician’s assistant (PA) or the advanced registered nurse practitioner (ARNP);

(e) the date the supply was distributed;

(f) the identification number assigned to the supply of the drug distributed by the health department or family planning clinic;

(g) the brand name or corresponding generic name of the drug;

(h) necessary auxiliary labels and storage instructions, if needed; and

(i) the beyond-use date of the drug issued.

(3) Repackaged drugs shall be packaged in suitable containers and shall be subject to all other provisions of the Kansas State Board of Pharmacy rules and regulations under the Pharmacy Act of the State of Kansas.

(D) The appointment of any Kansas licensed pharmacist as pharmacist-in-charge of a health department or family planning clinic shall be subject to the provisions of K.A.R. 68-1-2a and 68-7-13. (Authorized by and implementing K.S.A. 65-1648; effective, T-84-3, Feb. 10, 1983; effective May 1, 1984; amended July 23, 1999; amended **April 28, 2000**.)

Making A Home Visit

An important aspect of promoting the health of population has been the tradition of providing services to individual families in their homes. Home visits give a more accurate assessment of the family structure and behavior in the natural environment. These visits provide opportunities to observe the home environment and to identify barriers and supports for reaching family health promotion goals. The nurse is able to work with the client first hand to adapt interventions to meet realistic resources. Meeting the family on its home ground also may contribute to the family's sense of control and active participation in meeting its health needs.

Every agency providing home visits should have a well understood and practiced safety policy. Additionally, if the visit is to be valuable and effective, careful and systematic planning must occur.

Phases and Activities of a Home Visit

Phase	Activity
I. Initiation phase	Clarify source of referral for visit Clarify purpose for home visit Share information on reason and purpose of home visit with family
II. Previsit phase	Initiate contact with family Establish shared perception of purpose with family Determine family's willingness for home visit Schedule home visit Review referral and /or family record
III. In-home phase	Introduction of self and professional identity Social interaction to establish rapport Establish nurse-client relationship Implement nursing process
IV. Termination phase	Review visit with family Plan for future visits
V. Postvisit phase	Record visit Plan for next visit

References

Loveland-Cherry, C.J. (1996). "Issues in Family Health Promotion." In M. Stanhope and J. Lancaster (Eds.). Community Health Nursing. (4th Edition) St. Louis: C.V. Mosby Co.

Epidemiology and Nursing Practice

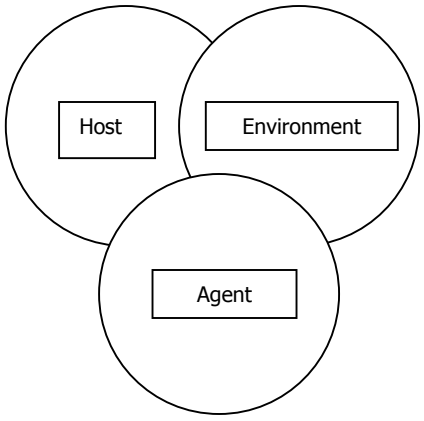
Epidemiology is the study of the distribution and determinants of state of health and illness in human populations. The goals of epidemiology are to prevent or limit the consequences of illness and disability in humans and maximize their state of health.

Scope of Epidemiology

The science of epidemiology emerged from the need to determine the cause of disease conditions so that prevention and control measures could be implemented. By observing groups of people rather than individuals, similarities and difference between those who have a health problem and those who don't can be identified. The scope of epidemiology has expanded in recent years from psychosocial problems, occupational injuries, and environmental concerns.

Epidemiologic Model

The basic epidemiologic model used in studying the distribution and determinants of states of health involves interaction of the host, agent, and environment. Host factors include age, sex, race and genetic makeup, nutrition, lifestyle, and motivation. Agents include physical, chemical nutrient, psychologic and biologic stressors. Environmental factors can be biologic, physical, and social.



The Epidemiologic Model

The principles of epidemiology are used in planning and evaluating health services. Individual lifestyles and health habits are strong determinants of health and disease. Characteristics that increase the probability that diseases will develop are called risk factors. Programs that enable peoples to control and improve their states of health by reducing risk factors. The process of health promotion, should be based on outcomes of epidemiology.

Levels of Prevention

Prevention of communicable and non-communicable diseases can be attained at three levels: primary, secondary, and tertiary. Primary prevention is aimed at reducing the incidence of disease through health promotion and education by preventing disease before it occurs. Secondary prevention is aimed at reducing prevalence of disease or diminishing its morbidity through early diagnosis and treatment. Tertiary prevention is aimed at reducing complications and disabilities related to the disease through treatment and mental and physical rehabilitation.

Disease Surveillance

Surveillance of diseases is an important public health function at both the state and local levels. It should include a continual method of close observation of all aspects of the occurrence and distribution of a disease through systematic collection. Orderly consolidation and analysis, and prompt dissemination of all relevant data. A surveillance system must be current, accurate, complete, purposeful, and dynamic to be useful for planning, implementation, and evaluation of disease prevention and control programs. It requires close communication and cooperation between the local and state agencies. The Kansas Department of Health and Environment maintains an Office of Epidemiology with a staff of health and environmental epidemiologists whose jobs it is to assist local health departments in disease surveillance. Early involvement of this staff provides a highly valuable resource in investigating and controlling prevalent diseases. (For the address and phone number of the Office of Epidemiology, the Epidemiologist on call, and the After Hours Pager Number, see the KDHE directory.) Another important desktop resource that provides a quick reference to understanding communicable diseases is the Control of Communicable Diseases Manual that is available from the American Public Health Association (see address below).

Objectives of Surveillance System include:

- Estimate the magnitude of a health problem
- Understand the natural history of a disease of injury
- Detect epidemics and evaluate control strategies
- Describe the distribution and spread of a health event
- Test hypotheses about etiology
- Monitor isolation activities
- Detect changes in health practices

Data Sources

Any health-related information that has been compiled about a group of people can be a source of data used to describe the distribution and determinants of heath. Epidemiologic data sources include but are not limited to: disease registries, health care institutions, insurance companies, industries, private physician offices, accident and police records, surveys, vital statistics maintained by the Kansas Department of Health and Environment, and schools.

Investigation

In order to accomplish a timely investigation, an active surveillance system must be in place. A method of having regular and timely contact with other health related agencies, doctors' offices, and with schools located in the jurisdiction of the local health department is helpful in identifying disease outbreaks. The first step in investigation the occurrence and distribution of health concerns is to describe the magnitude of the problem and the characteristics of the people who have or do not have the illness in terms of person, place, and time. It is important to attempt to identify the source of the disease and all persons exposed to the source of the disease and all persons exposed to the source or to a person who contracted the disease from a secondary source. Tools are available for investigating the following communicable diseases and can be obtained from KDHE Office of Epidemiologic Services:

Legionellosis
Viral hepatitis
E. Coli
Lyme disease
Malaria
Rocky Mountain Spotted Fever
Tularemia
Typhoid Fever

Tools for certain other communicable diseases may be found in the following manuals produced by KDHE:

"Control of Enteric Disease Outbreaks in Daycare"

"Foodborne Disease Outbreak Investigations"
"Tuberculosis Manual: Care and Control"

Data Analysis

Data must be analyzed in order to determine whether or not there is a health problem, and if so, the extent of the problem. The primary measurement used to describe either the existence of a problem or the occurrence of a problem is the rate. Rates are ratios that measure the quantity of a health related event in a specific population with a given time period. For information on how to calculate rates and for other epidemiology methods, see the Harkness reference listed below.

Disease Reporting

Requirements for disease reporting in the U.S. are mandated by state laws and regulations. Reporting to the Office of Epidemiology should occur immediately upon identification of the outbreak. In Kansas, physicians, nurses, hospitals, and laboratories are mandated to report to the Local Health Officer and/or the Office of Epidemiology. Kansas Statutes provide immunity for those who report and confidentiality for those who are reported. The list of reportable diseases in each state differs. PLEASE NOTE: OUTBREAKS OF ANY DISEASE ARE REPORTABLE.

Case Definitions

When identifying cases of any communicable disease, it is important that the cases meet the "Case Definition" as established by CDC and the Council of State and Territorial epidemiologists. Do not hesitate to report any suspected case to the Office of Epidemiology; the epidemiologists will assist you in determining whether or not a case meets the definition. Case Definitions may be found in the MMWR Recommendations and Reports, May 2, 1997, Vol. 46, No. RR-10 or you may obtain a copy from the Office of Epidemiology. The following are several other definitions of terms used in case classifications:

Clinically compatible case: A clinical syndrome generally compatible with the disease, as described in the clinical description.

Confirmed case: A case that is classified as confirmed for reporting purposes.

Probable case: A case that is classified as probable for reporting purposes.

Suspected case: A case that is classified as suspected for reporting purposes.

Laboratory confirmed case: A case that is confirmed by one or more of the laboratory methods listed in the case definition under Laboratory Criteria for Diagnosis.

Epidemiologically linked case: A case in which the patient has had contact with one or more persons who either have/had the disease or have been exposed to a point source of infection (i.e., all cases linked with the same source in a foodborne outbreak) and in which transmission of the agent by the usual modes of transmission is plausible.

References

Benenson, A.S. (Ed.) (1995). Control of Communicable Diseases Manual. 16th Edition. Washington, DC: American Public Health Association.

Centers for Disease Control. (1997, May). MMWR: Recommendations and Reports. Vol. 46: RR10. Atlanta, CA: Author.

Harkness, Gail A. (1995). Epidemiology in Nursing Practice. St. Louis: C.V. Mosby, Co.

Stanhope, M. & Lancaster, J. (1996). Community Health Nursing: Promoting Health of Aggregates, Families, and Individuals. 4th Edition. St. Louis: C.V. Mosby, Co.

To obtain copies of Control of Communicable Diseases Manual. ISBN # 0-87553-182-2:

Address:	American Public Health Association Publication Sales PO Box 753 Waldorf, MD 20604-0753
Web Page:	http://www.apha.org/media/abc1.htm
Phone:	301-893-1894 Customer Service Monday-Friday 9:00am-5:00pm (EST)
Fax:	301-843-0159 24 hours a day
Email:	apha@tasco1.com
Cost:	$29.00 members plus shipping and handling $40.00 non-members plus shipping and handling

Kansas List of Reportable Diseases

Disease reporting in Kansas is authorized by Kansas Statutes Annotated (K.S.A.) 65-118 and K.S.A. 65-128:

Reporting to local health authority as to infectious or contagious diseases; persons reporting; immunity form liability; confidentiality of information; disclosure.

The current list of reportable diseases was revised in the 1998 and may be found in Kansas Administrative Regulations (KAR) 28-1-2, 28-1-4, and 28-1-18.

Designation of infectious or contagious diseases.

REPORTABLE DISEASES IN KANSAS for health care providers, hospitals, and laboratories:

Acquired Immune Deficiency Syndrome (AIDS)
Amebiasis
Anthrax
Botulism
Brucellosis
Campylobacter infections
Chancroid
Chlamydia trachomatis infections
Cholera
Cryptosporidiosis
Diphtheria
Encephalitis infectious
Esherichia coli 0157:H7 (including hemolyticuremic syndrome)
Giardiasis
Gonorrhea
Haemophilus influenza, invasive disease
Hepatitis, viral and acute
Hepatitis, B, perinatal infection
Hepatitis B infection in pregnant woman
Hantavirus pulmonary syndrome
Human Immunodeficiency Virus (HIV) anon. reportable by physicians only)
Legionellosis
Leprosy (Hansen's disease)
Lyme disease
Malaria
Measles (rubella)
Meningitis, bacterial
Meningococcemia
Mumps
Pertussis (whooping cough)
Plague
Poliomyelitis
Psittacosis
Rabies, animal and human
Rocky Mountain Spotted Fever
Rubella, including congenital rubella syndrome
Salmonellosis, including typhoid fever
Shigellosis
Streptococcus pneumoniae, drug-resistant invasive
Syphilis, including congenital syphilis
Tetanus
Toxic shock syndrome, streptococcal and staphylococcal
Trichinosis
Tuberculosis
Tularemia
Yellow fever

Additional diseases reportable by laboratories only:

Blood lead level ≥ 10 μg/dl for persons< 18 years of age, and ≥ 25 μg/dl for persons ≥ 18 years of age: CD4+ T-lymphocyte count of less than 200/ml or c CD4+ T-lymphocytes less than 14

Additional diseases reportable by hospitals:

Acquired Immune Deficiency Syndrome (AIDS);
Cancer
Congenital malformations in infants under one year of age
Fetal-alcohol syndrome

CDC Universal Precautions Recommendations

General Recommendations

- All health care workers should routinely use appropriate barrier precautions to prevent skin and mucous membrane exposure when contact with blood or other body fluids of any patient is anticipated. These barriers include gloves, masks, protective eyewear, gowns or aprons according to risk of exposure for the employee.

- Hands and other skin surfaces should be washed immediately and thoroughly if contaminated with blood or other body fluids. Hands should be washed immediately after gloves are removed.

- All health care workers should take precautions to prevent injuries caused by needles, scalpels, and other sharp instruments or devices during procedures; when cleaning used instruments; during disposal of used needles; and when handling sharp instruments after procedures.

- Although saliva has not been implicated in HIV transmission, to minimize the need for emergency mouth-to-mouth resuscitation. Mouthpieces, resuscitation bags, or other ventilation devices should be available for use in areas in which there may be a need for resuscitation.

- Health care workers who have exudative lesions or weeping dermatitis should refrain from all direct patient care and from handling patient-care equipment until the condition resolves.

- Pregnant health care workers are not known to be at greater risk of contracting HIV infection than health-care workers who are not pregnant; however, if a health-care worker develops HIV infection during pregnancy, the infant is at risk of infection resulting from perinatal transmission. Because of this risk, pregnant health care workers should be especially familiar with and strictly adhere to precautions to minimize the risk of HIV transmission. Pregnant laboratory employees are to report a possible or confirmed pregnancy to their supervisor according to the laboratory safety policy.

Gloves

Gloves must always be worn when touching blood or other body fluids to which universal precautions apply. Gloves should be worn when touching contaminated instruments or surfaces. Gloves that have been contaminated should be removed as soon as possible. **Do not reuse gloves**. Dispose of contaminated gloves in leak-proof containers.

Hands should be thoroughly washed before gloving and after removing gloves, and immediately after contamination with blood, other body fluids, or articles contaminated by blood or body fluids that require universal precautions.

Masks and Protective Eyewear

Masks and protective eyewear should be worn when splashing of blood or other body fluids that require universal precautions is likely to occur.

Gowns

Gowns should be worn when soiling from blood or other body fluids that require universal precautions is likely to occur.

Needles/Instruments

Used needles should not be recapped, bent or broken by hand, removed from disposable syringes, or otherwise manipulated.

Disposable needles and syringes, scalpel blades, and other sharp items should be placed in puncture-resistant containers for disposal. Puncture-resistant containers should be located in the use area.

Instruments that penetrate tissue should be sterilized after each use. Those that do not penetrate tissue may receive high-level disinfections.

Clean-up and Disposal

Countertops, work areas, and surfaces soiled with blood or body fluids that require universal precautions should be disinfected with an EPA-approved germicide or a 1:10 solution of household bleach. Gloves should be worn while cleaning the areas. "International orange" plastic bags should be available for removal of contaminated items. For disposal of infectious waste in Kansas, see K.A.R. 28-29-27.

Soiled clothing and linen should be handled as little as possible and with minimum agitation. All soiled linen should be placed in leak-proof bags at the location where it was used. Personnel involved in the bagging, transport, and laundering of contaminated linen and clothing should wear gloves. Normal laundry cycles with detergent should be used.

References

Centers for Disease Control (1998). "Update: Universal Precautions for Prevention of Transmission of Human Immunodeficiency Virus, Hepatitis B Virus, and Other Blood Borne Pathogens in Health Care Settings." MMWR. 1988: 37(24): 377-88.

Centers for Disease Control (1989). "Guidelines for Prevention of Transmission of Human Immunodeficiency Virus and Hepatitis B Virus to Health Care and Public Safety Workers." MMWR. 1989:38(S-6).

See Administrative Section this manual for Bloodborne Pathogen Standard.

Infant, Child, and Adolescent Health Assessment

Quality health care for children and youth is a major goal and core public health service in Kansas supported by the Bureau for Children, Youth and Families in the Kansas Department of Health and Environment (KDHE). Health assessment of an infant, child or adolescent is commonly referred to as a Child Health Assessment.

Child Health Assessment

A comprehensive child health assessment includes: health history; physical examination; and vision, hearing, dental, nutrition and physical activity, speech and language, and development screens. The child's immunization status is reviewed and, if needed, vaccine administered. Laboratory tests are used to screen for lead levels, hemoglobin/hematocrit and urine samples. Anticipatory guidance and referral for treatment including the development of a follow-up plan complete the health assessment.

Child health assessments are provided by physicians, Advanced Registered Nurse Practitioners (ARNP) and professional registered nurses (RN) for children 0-21 years of age. Professional registered nurses are employed in public health departments, schools and day care centers, private physician offices, state institution and agencies, and private nursing practice. Health assessment is not within the scope of practice of a Licensed Practical Nurse (LPN). LPN's can perform many of the screening components within the assessment but the professional registered nurse, ARNP or physician must complete referral recommendations and develop a health supervision plan in collaboration with the family or guardian based on sound medical theory and professional practice. The Child Health Assessment assures quality comprehensive preventive infant, child and adolescent health services throughout the state.

CHANP Certification Discontinued

A change in protocol was made based on the determination that health screening assessment and referral are currently within the scope of practice of the professional registered nurse. Child Health Assessment Nurse Provider Certification (CHANP) was terminated as of July 2002. The certification process began, as a way of assuring a uniform professional preparation standard for nurses performing health assessments on infants, children and adolescents prior to the period of time health assessment became a common function of professional nursing practice. Health assessment, through a twenty-year transition phase, has become a part of professional registered nurse practice in Kansas and is incorporated in professional nurse preparatory curriculum.

KDHE continues to provide continuing education opportunities for nurses in the area of infant, child and adolescent health assessment and encourages the use of Bright Futures Guidelines for Health Supervision for Infants, Children, and Adolescents and other Bright Futures materials as a standard of care in Kansas. Bright Futures materials are a set of expert guidelines and a practical development approach to providing health supervision for children of all ages, from birth through adolescence. Bright Futures materials are promoted through a cooperative agreement of the American Academy of Pediatrics and the Maternal Child Health Bureau. Materials can be accessed on the web at http://www.brightfutures.org. Orientation in the use of Bright Futures materials is available through the Area Health Education Centers (AHEC) throughout Kansas by contacting:

Mary Beth Warren, RN, MS, CPHQ	Telephone:	620-235-4040
1501 S. Joplin, PO Box 296	Fax:	620-235-4041
Pittsburg, KS 66762-0296	Email:	mwarren@mail.pittstate.edu

Local Health Department/Correctional Facility Issues

In the past fifteen years correctional facility health care services have literally transformed from basic emergency maintenance to complex and comprehensive total care including ancillary services such as dental, orthopedic, prenatal, and inpatient-convalescent care. In addition to burgeoning health care costs and increased inmate populations, correctional facilities must also confront nationwide nursing shortages, escalating salaries for technical medical personnel, the AIDS epidemic, new legislation, heightened regulation, and standards of care. In many cities, correctional facilities have become the caretakers in the community, the medical shelters and barometers by which we judge the level of caring and compassion.

In many states including Kansas, local correctional facilities (city and county) are autonomous and under the direction of the sheriff or director of the local facility in question. The state agency, Kansas Department of Corrections (KDOC) only has jurisdiction over the state correctional facilities and parole offices. Operational responsibility of local facilities is frequently delegated or contracted to a city, county, or private health services provider, thus many local health departments have become involved with inmate care to perform a variety of duties often with no standard guidelines or contracts.

A primary concern in this area is protecting the nurse personally and professionally. Without standards or contracts, responsibility can become an extremely gray area. There must be a clear understanding of who is in charge of health care in the facility and it is **not** the local health department nurse.

Written memoranda of understanding with clearly defined lines of authority and communication, defined roles and responsibilities for medical and custody programs and personnel, and an orientation program for all new staff must address, among other things:

1. The distinct yet mutually supportive roles of medical and custody staff
2. Security policies and procedures
3. Special needs of the health services program (e.g., confidentiality of medical information).

Nurses providing services to prison inmates should ask themselves the following questions:

- Is there a written signed contract?
- Is there extra reimbursement for this service?
- Is it specifically listed in my current job description?
- Do I have a job description?
- Are there standardized protocols?
- Who is ultimately in charge of inmates' health care?
- Who is responsible to whom?
- What about weekends or after hours? Vacations?
- What about liability?

Growing concerns in litigation include lack of access to health care services, and disregard of physician's orders by both medical and custodial personnel. For example, dispensing medications—who does it, under whose supervision, under what circumstances—is often raised in litigation. At the same time, inmates have a right to refuse medical care unless that refusal poses a threat of serious bodily harm.

These clients are "high risk" for several reasons: 1) most are not in good health or physical condition; 2) many are mad at the world, and particularly at those whose name or face they can remember; 3) they have time on their hands, time to plan and write letters; 4) they may have devious reasons for complaining, i.e., wanting out, in, moved, or attention.

Historically in the smaller institutions, correctional facilities health services personnel have been assigned functions without regard to their legal parameters of professional practice as defined by individual professional license provisions and common practice in the health care community. These practices are no longer acceptable as courts insist on qualified licensed, competent health care personnel working within

their scope of practice in correctional health care programs. These personnel can be held personally liable, risk the loss of their licenses, and leave their employer open to the very real hazard of being sued for their acts an omissions. And if county health department personnel, (i.e., nurses), are sued, the county government employer, (i.e., county commissioners) is likely to be named in the suit also. Thus, it becomes even more important to be aware of current "scope of practice" regulations (i.e., the Nurse Practice Act).

There are, however, some specific advantages to county/city health agency operated programs. These include management by health care professionals oriented toward public health service delivery, who know county/city resources and have established linkages with other services in the community such as substance abuse programs, social services, nutritional services, etc. Also there may be enough personnel within the system to provide back-up coverage. Negative aspects include the fact that the correctional facility will not be the only or top priority, and often they are the provider of last resort and unwilling or unenthusiastic about providing the service.

The American Medical Association has written a set of "Standards for Health Services in Jails" to bring medical resources into a facility for routine care and allow for transferring out inmates with extra-ordinary needs. This standard is not mandatory but should provide a local facility with some guidelines in order to set up specific policies. Completion of this task is the responsibility of the person in charge of the facility, not the public health nurse who may be providing services. A copy of the American Medical Association Standards should be available through KDOC, Landon State Office Building, Suite 404N, 900 SW Jackson, Topeka, KS 66612-1284. Materials are also available through the National Institute of Corrections, 1860 Industrial Drive, Longmont, CO 80501.

References

AMA Standards for Health Services in Jails (1980, July). "AMA Program to Improve Medical Care and Health Services in Jails Reference Guide and Practical Workbook."

Arizona Department of Corrections Quality Assurance Plan (1988). AZ Department of Corrections, Health Services Bureau.

Jail Medical and Health Care Services: Relevant National Standards for Inclusion in Policies and Procedures. Prepared by Martin Drapkin, Director, Jail Policy Consultants, PO Box 9062, Madison WI 53715.

State of California Board of Corrections. Guide to Planning and Evaluating Inmate Medical/Mental Health Services. Prepared by Norman & Cotton Associates, Inc.

Nursing Models

School Nursing

School nursing developed in our country shortly after the turn of the century as an outgrowth of the public health movement at the time and as an extension of public health nursing into the schools for the purpose of both communicable disease control and to assure that children were healthy and attending school. Given their direct access to children, families and school personnel, school nurses are in a unique position and have the skills and knowledge to improve children's health and their ability to learn.

Changes in society, structure of the family, special education legislation, and changes in the health care and educational systems have increased the need and demand for health services and clinical nursing services in schools. School nurses today provide health services for children and youth (3-21 years old, including some from birth to 3 years of age in early intervention programs) with acute, chronic, episodic and emergency health care needs and problems. The school nurse assesses students' health status; identifies health problems which may influence a student's educational program and/or need additional evaluation; develops a health care plan for management of health care problems in the school setting; intervenes in emergencies; administers medications; performs special health care procedures (e.g., gastrostomy tube feeding); provides health education and health counseling for students and families; advocates for students with disabilities; provides health/wellness programs for school employees; is involved in program planning, development, management and evaluation; and provides outreach to families and linkage with community-based health agencies.

Several significant issues, however, must be addressed in order to maximize these expanded school nursing services. These issues are: 1) unclear definition of the school nursing role; 2) educational preparation of school nurses; 3) administration and supervision of school nursing services; 4) funding; and 5) legal/clinical practice dilemmas.

Varied responsibility is but one of several factors which lead to confusion about the role of the school nurse. This role confusion is further influenced by other factors—the practice setting and educational preparation of the school nurse. Provision of health care in a non-health care setting (i.e., the school) provides some unique challenges. The primary mission of the school system is to educate the student, not provide health care. The goal, then, of health care services in the school is directed toward promoting optimal student wellness and enhancing the educational program of the student.

The National Association School Nurses (1990) affirmed that the baccalaureate degree from an accredited college or university should be the preparation for entry into school nursing. Given the nature and complexity of student health problems and nursing practice today, the level of knowledge, skill and decision making necessary in school nursing practice demands the competencies acquired in a baccalaureate nursing program. In current practice, preparation of school nurses varies from associate degree to masters prepared registered nurses. LPNs may provide limited health services only under RN supervision.

Another recurring issue that needs to be addressed is the lack of discipline specific supervision, consultation and role modeling. The administration and supervision of school nursing services are frequently positioned under the administration of a non-health care professional with no direct accountability for nursing personnel to a nursing supervisor. This leads to an often-controversial issue of whether the administration of school health services be housed within the education department of the health department.

Funding for school health services (including nursing personnel) is usually generated from education dollars. The number of school nurse positions and their educational preparation level is often determined by the availability of budget monies rather than by student or community health care needs.

Numerous professional-legal dilemmas have recently emerged due to the nature of school health services, legislation and current school nursing practice. These dilemmas include those relating to school health records, collection, storage and release of confidential student health information, and delegation of nursing care responsibilities to unlicensed assistive personnel.

In response to these issues, school systems have begun to redesign school health services and delivery systems in order to address primary health care access for students and to better provide services to those at risk, and the uninsured or underinsured. Such models include the school based clinics and family health centers.

In order to form a more complete picture of the evolving role of the school nurse, several evident societal and health care trends will likely influence school nursing in the future. These trends are seen as landmarks of the future health landscape and certainly will influence the future of school nursing:

- Expansion of technology
- Changing disease trends
- Shift of health care delivery to the community setting
- Paradigm shift to leadership through collaboration
- Inquiry regarding client health care outcomes
- Increase number of public health issues requiring attention in school systems
- Increase number of children requiring case management

References

Kansas Department of Health & Environment, Bureau for Children, Youth, and Families, 2002. http://www.kdhe.state.ks.us School Nursing and Integrated Child Health Services.

Passarelli, Carole. (1993, November). "School Nursing: Trends for the Future." National Health/Education Consortium.

Parish Nursing

The Church has always been a source of hope and healing, the place where people turn in time of need. In the Early Church, deacons, church workers, and women were providers of health care, with a commitment to the whole person (Beal). Over the years, with the establishment of institutions to care for the ill, the availability of health insurance, and the recognition of health care as a business, churches relinquished their health and healing ministries to secular agencies (Matthaei & Stern).

The modern concept of congregation-based health ministries was founded in the U.S. as recently as 1983 by Dr. Granger Westberg, a Lutheran Pastor who served as a hospital chaplain at Lutheran General Hospital in Chicago (Beal). Parish nursing, the fastest growing specialty nursing practice and the fastest growing lay ministry in the church, best exemplifies the delivery of wholistic care, physical, emotional, mental, and spiritual. With congregational support, the health ministry of the parish nurse fulfills the church's mission to its members and to the community. It extends into the community system and collaborative with other community health agencies as well as with the public health department.

The goal of the parish nurse program is to help individuals from church populations stay well, to bring the church to the individual member and families in times of need, to create a feeling of deeper caring within the church membership, and to bring Christ to those in physical, mental, emotional, and spiritual distress. The parish nurse, a registered professional nurse, brings her knowledge and professional experience into her service to Christ. Because of the different professional backgrounds of parish nurses and the demographics of the church, each health ministry is unique to the congregation in which it exists.

Parish nurses assess congregation for distribution of age groups, church setting, general socio-economic of church members, health status and health needs. They serve all ages, socio-economic, and ethnic groups in their church (Mikulencak). Parish nurses work in a team ministry with the Pastor, consulting, making referrals, visiting patients/families, and praying for the sick. The parish nurse also works as a coordinator with other health care professionals and laypersons as they work in teams to provide needed care. The nurse is often a calm and prayerful presence in a family crisis and often is called on to find needed health related resources. For those who cannot be cured, parish nurses offer a healing of the spirit for patient and family.

The parish nurse, an integrator of faith and health, accomplishes the tasks through five major roles. These include serving as health educator, health counselor, health promoter, recruiter and trainer of volunteers, and a referral resource. It is important to emphasize that parish nurses do not generally provide invasive or direct hands on physical care. Parish nurses do not provide home health care. Rather the nurse finds appropriate needed resources, i.e., an established home health agency. It is notable, however, that as resources become scarce, parish nurses are asked with increasing frequency to provide home care. Most parish nurses are also employed as full time nurses in a health care agency, serving on a part-time, volunteer basis in the church, and would not have time to provide 24 hour, 7 day a week service. Medical supplies and liability are also two reasons that the parish nurse is not in a position to provide home health care.

Care provided is documented and information obtained, whether written or verbal, is confidential. Parish nursing practice is governed by the State Nurse Practice Act, the American Nurse's Association Code of Ethics and the Scope and Standards of Parish Nursing, and the HIPAA Act.

The models of parish nursing are either church-based or institutional bases, i.e., hospital, nursing home, or other community agency. Nurses may be a salaried or unsalaried and they may serve on a full-time or part-time basis. Most parish nurses are part-time and they volunteer their services. In a few instances, churches may contract with a nurse for specific services for which she is paid.

A Health Board or Cabinet should be established within the church structure to assist in the development and maintenance of the health ministry, support and advise the nurse(s), and to collaboratively plan new and ongoing programs. The Health Board is composed of other health care professionals in the church, as well as other interested persons. Usually five to nine people make up this working group. The Board members may also assist with preparing the budget for the parish nurse ministry program (Westberg and McNamera).

Considering today's trends toward managed care, per capita reimbursement, and decline in government supported research programs, all efforts that support wellness in our communities are welcome. Churches, through the use of health and healing ministries, are active contributors to this goal.

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Mikulencah, M. (1992). "The Satisfying Role of Parish Nursing." The American Nurse. 24(9), 10.

Shelly, J.A. (2002). Nursing in the Church. NCF Press, Madison, WI.

Solari-Twadell, P., Dupe, A., & McDermott, M. (1990). Parish Nursing: the Developing Practice. National Parish Nurse Resource Center, Lutheran Care General System.

Westberg, G. & McNamara, J. (1987). The Parish Nurse. Park Ridge, IL: Parish Nurse Resource Center.

Resources

Deaconess Parish Nurse Ministries (formerly the International Parish Nurse Resource Center)
St. Louis, MO
314-918-2527
http://www.advocatehealth.com/system/about/community/faith/advpnurs.html

Continuing Education Division
Concordia University Wisconsin
Parish Nursing Distance Learning Program
12800 N. Lake Shore Drive
Mequon, WI, 53097
262-243-4233
262-243-4466 (fax)
carol.lueders.bowerk@cuw.edu email address for Carol A. Lueders-Bolwerk
http://www.cuw.edu/parish_nurse/distance_learning.htm

Center for Congregational Health Ministry
3600 E. Harry
Wichita, KS 67218
JoVeta Wescott
800—851-0051 ext 5152
316-689-5152
http://www.via-christi.org/cchmweb.nsf/mainview

Congregational Health Ministry
(Lutheran Church Missouri Synod)
1333 Kirkwood Road
St. Louis, MO 63122
314-965-9917 ext. 1395
http://humancare.lcms.org/hm/pn.htm

Journal of Christian Nursing
PO Box 7895
Madison, WI 53707
608-274-4823
email: ncf@ivc.org

Health Ministries Association
980 Canton St. Bldg 1, Suite B
Roswell, CA 30075
800-280-9919
770-640-9955
770-640-1095 (fax)
email: hmassoc@mindspring.com
http://www.healthministriesassociation.org

Environmental Nursing

Environment health concerns, the historical development of the nursing profession and core nursing values all fit together for the environmental nurse. Early in the nineteenth century, Florence Nightingale emphasized that the nature and quality of the patient's physical environment are determinants of the patient's recovery of health. As nursing evolved, however, more emphasis was placed on other types of social relationships and their impact on human health.

Environmental issues have mushroomed, however, so that today the environment is considered as one of the primary determinants of individual and community health. Environmental health refers to freedom from illness or injury related to exposure to toxic agents and other environmental conditions that are potentially detrimental to human health. Its practice is interdisciplinary. Environmental hazards are ubiquitous, insidious, and often poorly understood. They may be sentinel disease or involve the entire community or they may be small nuisance or pollution issues. The key is having a potential detrimental effect on the health of a population. Exposures occur in the home, work place, and community.

Nurses are well positioned for addressing environmental health concerns of individuals and communities. They are the largest group of health professionals, have greater variety in their settings and locations of practice, environmental health fits with values of the nursing profession regarding disease prevention and social justice, and nurses are trusted by the public. Nurses are often the first point of contact, talk in-dept with patients and frequently provide on-site care. Assessment and evaluation of the population, including environmental health, is a core function of public health nursing.

Environmental nursing can easily be considered a specialty, and several other closely related specialties do exist. All nurses, however, should have an increasing environmental health awareness and content, regardless of their particular practice or educational preparation. For example, maternal and child health nurses screen children who may have been exposed to residential lead-based paint or pesticides on farms; emergency room nurses see individuals exposed to toxic wastes or environmental poisons, occupational health nurses may screen for workplace exposures, and pediatric nurses might link childhood illnesses to toxins transported from a parent's workplace to the home. Any nurse caring for economically disadvantaged patients should be aware that these populations face increased risk of exposure to hazardous pollutants.

The 1994 IOM report which dealt specifically with environmental nursing practice produced a set of general **environmental health competencies for nurses** which extend but are continuous with, nurses' existing roles as investigators, educators and advocates.

I. Basic knowledge and concepts

All nurses should understand the scientific principles and underpinnings of the relationship between individuals or populations, and the environment (including the work environment). This understanding includes the basic mechanisms and pathways of exposure to environmental health hazards, basic prevention and control strategies, the interdisciplinary nature of effective interventions, and the role of research.

II. Assessment and referral

All nurses should be able to successfully complete an environmental health history, recognize potential environmental hazards and sentinel illnesses, and make appropriate referrals for conditions with probable environmental etiologies. An essential component of this is the ability to access and provide information to patients and communities, and to locate referral sources.

III. Advocacy, ethics, and risk communication

All nurses should be able to demonstrate knowledge of the role of advocacy (case and class), ethics, and risk communication in patient care and community intervention with respect to the potential adverse effects of the environment on health.

IV. Legislation and regulation

All nurses should understand the policy framework and major pieces of legislation and regulations related to environmental health.

Occupational Nursing

Occupational nursing is environmental nursing in the workplace. Nurses are by far the largest group of health professionals providing care in occupational settings. This proximity to the workplace enables nurses to identify and initiate measures to remediate workplace hazards if adequately educated to do so. Nurses must also recognize their professional obligation to advise employers and employees of real or potential hazards and where necessary to initiate steps to control or eliminate hazardous conditions.

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LEGAL ASPECTS OF PUBLIC HEALTH

Public Health Law

The reach of public health law is as broad as the reach of public health itself. Public health and public health law expand to meet the needs of our society. At the turn of the century, public health and its legal regulation covered the prevention of communicable disease and environmental sanitation, which included some concern for water purity and housing hygiene, limited interest in food and milk sanitation, some incipient school health controls, and very little else. Today, the field has expanded to encompass enlarged and more sophisticated concerns for physical and mental health, including vast new systems of social insurance to provide for the medical care of the aged (Medicare) and the "medically indigent" (Medicaid) broad environmental concerns such as the control of air and water pollution, conventional waste, toxic and hazardous waste, and pollution by ionizing radiation; the control of food, drugs, and a variety of aspects of human reproduction; population control; and the control of the uses of addictive substances such as alcohol, drugs, and tobacco.

1. The Relationship Between Public Health and the Law

The professions of public health and public health law have changed and expanded, not only IN the subject matter covered, but also in the nature of their work. The programs that existed at the turn of the century were almost exclusively regulatory—that is, they told industry and people what to do and what not to do. Public health and public health law today do a great deal more. Although many public health programs are regulatory, most are service oriented. They seek to enhance public health not only be prohibiting harmful activities or conditions but also by providing preventative and rehabilitative services to advance the health of people, instead of regulation. Policing, and prohibiting unwholesome conduct or conditions, public health and public health law provides services to create a more healthful environment and provide the facilities and the trained professionals to prevent disease, to treat disease, to educate people, and to improve conditions.

The expansion and development of the field of public health rely on law. No single service or regulatory program of public health exists without legal authorization. Law is essential to public health because public health programs are entirely dependent on *legislative* authorization. Any doubt on that score can be readily resolved by looking at the authorization or appropriation for any health related activity. Any remaining doubts may be set to rest by examining the provisions of the U.S. Code that deal with public health, the public health law of any of the 50 states, and the provisions of local codes and ordinances that deal with matters of health and safety. It is an impressive, all-encompassing legal structure. It must be extensive because every public health activity must find its origins in some part of that legal aggregate.

2. Bases of Authority for Public Health Programs and Activities

Governments—federal, state and local—exercise great powers in the field of public health. Because of the nature of our federal system of government, public health law has an origin at the state and local levels different from is basis in federal law.

Source of State and Local Power

In the states, government authority to regulate for the protection of public health and to provide health services is based on the "police power"—that is, the power to provide for the health, safety and welfare of the people. It is not necessary that this power be expressly stated, because it is a plenary power that every sovereign government. For purposes of the police power, the state governments—which antedate the federal government—are sovereign governments. It might be added that the exercise of the police power is really what government is about: It defines the very purpose of government. Thus, on the state level, the power to provide for and protect the public

health is a basic, inherent power of the government. The state also delegates the exercise of the police power to lower levels of government: at the level of divisions of state governments; at the county or parish level; or at the municipal, city, or village level. Many state and local regulatory programs rely on the police power, which includes the promulgation of health and sanitary codes, hospital and nursing home codes, and housing and plumbing codes, as well as health services such as municipal hospital systems and school health services.

Sources of Federal Power

Although public health powers were first exercised at the state and local levels, today the federal government plays a major part in the regulation of public health and the provision of health services. The federal government, unlike the states, is not a government of plenary powers. It only has the powers that the states originally delegated to it through the federal Constitution. It does not have the police power, because a reading of the powers delegated to Congress will show that the police power—to provide for general health, safety and welfare—is not one of the powers delegated.

Federal powers in public health rest largely on the "commerce power," the power of Congress to "regulate commerce with foreign nations, and among the several States, and the Indian tribes," under Article I, Section 8, Clause 3, of the U.S. Constitution. Public health powers also rest on the so-called taxing and spending power, to "collect taxes…to…provide for the…general welfare of the United States," under Article 1, Section 8, Clause 1.

The power to regulate interstate commerce allows Congress to regulate whatever passes in commerce between states as well as whatever affects interstate commerce. The interstate commerce power provides authority to Congress, and to the federal government, to regulate *directly* the commercial transactions between the states, as well as everything that passes in interstate commerce. The Federal Food, Drug, and Cosmetic Act furnishes a notable example of the exercise of direct regulatory powers. Under that law Congress has provided for the wholesomeness of food, and for the safety and efficacy of drugs and medical devices sold in interstate commerce. Because large businesses that manufacture and sell foods and drugs generally operate nationwide, the Food and Drug Administration (FDA), by delegation from Congress under the Act, controls or regulates what goes into virtually every bottle of medicine, pill, salve, or ointment. The commerce power involves direct federal regulatory control by a federal agency that promulgates its own regulations pursuant to law and that employs and oversees its own staff of professionals, administrators, inspectors, and other enforcement personnel.

The range of direct federal regulatory activities with public health implications under the commerce power is very broad. It includes, for example, the slaughter of beef and the manufacture of beef products under the Federal Meat Inspection Act and the production, slaughter, and sale of poultry under the Poultry Products Inspection Act. It includes the production and sale of pesticides and other economic poisons under the Federal Insecticide, Fungicide, and Rodenticide Act, as last amended in 1978, the production and sale of toxic substances, under the Toxic Substances Control Act, and the control of unsafe consumer products under the Consumer Product Safety Act. All of the laws and many other involve direct federal controls, and all of them, in their legislative findings and in their standards, refer to the protection of health as their main purpose.

Other federal legislation—for example, that relating to wages and hours of workers under the Fair Labor Standards Act, and the health and safety conditions under which work is performed under the Occupational Safety and Health Act (OSHA)—were enacted under the commerce power and have far-reaching implications for public health.

Kansas Public Health Statutes and Regulations

State public health statutes are enacted by the state legislature. Regulations, on the other hand, are set by administrative agencies, such as the Kansas Department of Health and Environment. The legislature generally delegated authority to administrative agencies to establish regulations that support statutory policies.

State statutes including those pertaining to public health are referenced in Kansas Statutes Annotated, and state regulations are referenced in Kansas Administrative Regulations. These references may be found in government offices, libraries, law offices, and law libraries. In addition, individual city, county, and township ordinances are referenced at local libraries and government offices.

For current reference regarding Kansas's public health laws, each county public health office is encouraged to obtain and maintain the manual, A Selection of Kansas Public Health Statutes and Regulations, published by the Kansas Public Health Association (KPHA) and the Kansas Department of Health and Environment. The manual is available from KPHA headquarters.

The following list highlights some frequently referenced Kansas public health statutes:

K.A.R. 28-1-5	States that "when conditions of isolation and quarantine are not otherwise specified by regulation, the local health officer of the secretary of health and environment shall order and enforce isolation and quarantine of persons afflicted with or exposed to infectious or contagious disease." That same regulation sites the "isolation or quarantine shall be ordered in conjunction with investigation of infectious or contagious disease cases and outbreaks for the examination of person reasonably suspected of having these diseases, and to obtain specimens form these persons for laboratory evidence suggestive of infectious or contagious disease."
K.S.A. 47-125	Impoundment of biting animal
K.S.A. 65-118	Reporting of contagious diseases; immunity from liability, confidentiality of information; disclosure
K.S.A. 65-126	Gives Secretary of KDHE authority to "quarantine any area in which any of these diseases may have a tendency to become epidemic" and implies that the same power is give to the local health officer.
K.S.A. 65-129	Reinforces the authority of the local health officer to establish a quarantine
K.S.A. 65-159	Duties and powers of local health officers in contagious diseases
K.S.A. 65-163	Public water supply systems
K.S.A. 65-201	Local boards of health; local health officers
K.S.A. 65-241; K.S.A. 65-242	State financial assistance to local health departments
K.S.A. 65-6001 - K.S.A. 65-6007	AIDS/HIV
K.S.A. 72-5214	Health assessment at school entry

Child Abuse

Abuse/Neglect

In Kansas, physical, mental, or emotional abuse or neglect means the infliction of physical, mental, or emotional injury or causing of a deterioration of a child and may include, but shall not be limited to:

1. Failing to maintain reasonable care and treatment
2. Negligent treatment or maltreatments
3. Exploiting a child to the extent that the child's health or emotional well-being is endangered

A parent legitimately practicing religious beliefs who does not provide specified medical treatment for a child because of religious beliefs shall not, for that reason, be considered a negligent parent. However, this exception shall not preclude a court from entering an order.

NOTE: Abuse and neglect statutes do not differentiate between accidental and non-accidental injury, nor is there any provision to exclude spanking from application of Kansas's statutes. A child is defined as any child under age 18. The reporter does not have to determine if child abuse or neglect exists-only that there is reason to believe or suspect such concerns. Other children in need of care means a child less that 18 years of age who:

1. is without adequate parental care, control, or subsistence and the conditions are not due solely to lack of financial means of the child's parents or other custodian.
2. is without the care or control necessary for the child's physical, mental or emotional health
3. has been placed for care or adoption in violation of law
4. has been abandoned or does not have a known living relative
5. is not attending school as required by K.S.A. 72-1111 and amendments thereto.
6. while less than ten years of age, commits an act that if done by an adult would constitute the commission of a felony or misdemeanor as defined by K.S.A. 21-3105 and amendments.

Sexual Abuse

The exploitation of a child sexually includes fondling, salacious language, forced sexual touching, sodomy, intercourse, and other sexually stimulating activities such as pornophotograph and exhibitionism.

Who Shall Report

1. Persons licensed to practice healing arts or dentistry
2. Persons licensed to practice optometry
3. Persons engaged in post-graduate training programs approved by the Board of Healing Arts
4. Certified psychologists
5. Licensed professional or practical nurses examining, attending, or treating a child
6. Teachers, school administrators, or other employees of a school which the child is attending
7. Chief administrative officers of medical care facilities
8. Child care facilities and employees where care is being provided to the child
9. Licensed social workers
10. Fire fighters
11. E.M.T.s
12. Law enforcement officers

Penalty for not Reporting

K.S.A. 38-15-22: Willful and knowing failure to make a report required by law is a Class B misdemeanor. Punishable up to a fine of $1,000 and six months imprisonment.

Prohibition from Imposing Sanctions on Employee Making Reports

No employer shall terminate the employment of, prevent or impair the practice or occupation of, or impose any sanction on any employee because the employee made an oral or written report. Violation of this section is a Class B misdemeanor.

Immunity from Liability

Anyone participating without malice in making an oral or written report to law enforcement or the Department of Social and Rehabilitation Services (SRS) relating to an injury inflicted upon a child under 18 years of age as a result of physical, mental, or emotional abuse or neglect or sexual abuse **shall have immunity** from any liability, civil, or criminal. Any such participant shall have the same immunity with respect to participation in any judicial proceedings resulting from the report. SRS does not reveal the name of the reporter. This information will **only** be revealed upon specific order of the judge (extremely rare).

When are Reports Made?

Reports shall be made when any of the mandated persons has reason to suspect that a child has been injured as a result of physical, mental, or emotional abuse or neglect or sexual abuse. **Report promptly!**

Note: the SRS *Kansas Youth Services Manual* defines "reasonable" as the faculty of the mind by which it distinguishes truth from falsehood and which enables the processor to deduce inferences from facts or from propositions. Reports may be made orally and **shall be followed by a written report if requested** (K.S.A. 38-1522). Report to the SRS district office or law enforcement officials in your area.

Reporting Information Needed by SRS

Every report (in person, by phone, or written) shall contain, if known:

1. Names and addresses of the child and parents or caretaker
2. Child's age
3. Nature and extent of injury (including evidence of previous injuries)
4. Any other helpful information

Reports to Coroner

Any person mandated to report an injury to a child and who had reasonable cause to suspect that a child died from injuries resulting from physical, mental, or emotional abuses or sexual abuse shall notify the coroner of that suspicion.

Responsibilities of SRS

1. Reports constituting suspected child abuse/neglect of any child under age 18 will be investigated. (Response time varies from immediate crisis intervention for a child in danger to seven days for neglect.)

2. All "runaway" children under age 12 will be investigated (within 30 days per site policy). Parents may be required to come into the office for an interview.

3. Any report on a "runaway" child that presents evidence of abuse/neglect in the family will be investigated. Previous reports on that specific child assessing the nature and severity of any previous reports.

4. If parents request services from SRS, they will be required to come into the office for an interview and sign a written application agreeing to actively work with SRS (if the child is a "runaway" and not returned home, services can not begin until child has returned.) SRS services do not include looking for, locating, or returning a "runaway" child to home.

5. SRS will tell parents requesting services that the goal is to maintain the child in the home. Parents will also be advised that they must seek other community and/or state hospital resources before placement is considered.

6. When placement of a child is ordered by a court, parents will be assessed a monthly fee to contribute to the ongoing support of their child. (Court costs may also be assessed to the parents by the court.)

7. Youth who are harmful to themselves/others may be referred (with family) to mental health services for immediate intervention.

8. Parents whose children over age nine are committing acts which would constitute miscreant or delinquent behavior will be advised to file charges in order to protect themselves or any other children in the home.

9. Parents of children under age ten committing miscreant or delinquent acts will be contacted by letter for an interview. Response time is up to 30 days. Parents may make written application for services in which they agree to actively work with SRS.

Children not Attending School

Effective July 1, 1986, children ages 7-13 who are not attending school shall be reported to SRS. Children 13-16 and children under 18 who are receiving Special Education Services and are not attending school shall be reported to the county attorney.

When a Child needs Protective Custody

1. SRS can only take a child into protective custody when a written court order is received. (SRS cannot transport or otherwise take possession of a child without written court order.) To obtain a court order, a child in need of care petition must be filed by the district attorney's office.

2. Law enforcement can take a child into protective custody. If it is their judgment a child is in danger, law enforcement may take a child into protective custody for 48 hours (excluding Saturday, Sundays, and legal holidays). The district attorney has the authority to release the child prior to or at the ending of 48 hours. (If no petition is filed, the child is released.) Law enforcement does not need a court order if the child is in danger. Law enforcement may take protective custody of a child if an order of the court has been made.

Confidentiality

The Kansas Code for Care of Children mandates the confidentiality of all records and reports concerning child abuse and neglect filed with SRS or with law enforcement agencies and sets forth when disclosure of information may be authorized by the Secretary of SRS, the judge of the court where the report is filed, or by the law enforcement agency.

Specific rules on disclosure of all records and reports of child abuse and neglect Section 38-1507, Kansas Code for Care of Children:

1. Records and reports concerning child abuse and neglect shall be disclosed to the court upon the order of any court of record.
2. The judge of the court where the report is filed, the Secretary of SRS, the district manager acting in behalf of the secretary or the law enforcement agency may authorize access to such records and reports to:

a. a person licensed to practice the healing arts who has before him or her the child the named in the report whom he/she reasonable suspects may be abused or neglected;
b. an agency having the legal responsibility or authorization to care for, treat or supervise the child who is subject of a report record;
c. the parent, guardian, or other person(s) named in a report of record with protection for the identity of reports and other appropriate persons;
d. police or an other law enforcement agency investigating a report of known or suspected child abuse or neglect; and
e. an agency of another state charged with the responsibility of preventing or treating physical or mental abuse or neglect of children within the state, if the state agency requesting the information has standards of confidentiality as strict or stricter than the requirements of the Kansas Code for Care of Children, Section 7, 38-1507.

Comments on Confidentiality

1. Information may be released to a non-custodial parent if parental rights have not been severed.
2. When a reporter makes a report to SRS, he/she may request a response. SRS is authorized in this instance to inform the reporter of the completion of the investigation. The reporter may be told that the investigation has been completed, the child has been seen, and the safety/welfare of the child ensured (*Kansas Youth Services Manual*).
3. SRS should inform the school administrator when a child is placed in protective custody.
4. SRS may not share information with a school as to whether or not a case is open if the school is not making a report.

Interviewing the Child in a School Environment

SRS guidelines recommend that a child be interviewed at school when a report alleges that a child:

1. has been injured by a parent or caretaker.
2. is fearful that such an injury or further abuse might occur imminently
3. has been sexually abused or exploited.
4. is a victim of serious neglect, the effects of which can be readily observed.

A child may be interviewed at school as authorized by K.S.A. 1982 Supp. 38-1532 Re: Cooperation between school personnel and investigative agencies. Administrators of elementary and secondary schools shall provide employees of SRS and law enforcement access to a child in a setting on the school premises determined by the school personnel for the purpose of the investigation of a report of suspected child abuse or neglect. SRS staff:

1. are expected to contact the designated school administrative staff when requesting an interview.
2. are expected to properly identify themselves.
3. are informed that the school cannot authorize an appropriate person to be present at the interview. This will be left to SRS and law enforcement discretion.
4. are expected to advise school personnel of any immediate action being taken.
5. may interview a child at school without parental consent, (K.S.A. 38-1526 amended).

Characteristics of Abuse or Neglectful Parents or Caretakers

Child neglect and abuse crosses all ethnic and socio-economic strata. Abusers are laborers, white-collar workers, and highly trained professional people. They are poor or wealthy; from very well kept to sub-standard surroundings. Intellectual ability and marital status do not make a significant difference.

Abusive parents often have very high expectations for their children and themselves. There is a great demand for performance clearly beyond the ability of most infants going through normal development (e.g., a child may be expected to walk at five months and be toilet trained at one year). When the child fails to meet these high expectations, parents feel frustrated, disappointed, and that they are failures. They also have feelings of being unloved and insecure. Abusive parents are often very lonely, depressed people. They have few, if any, family or social contacts and expect their children to meet these emotional needs. A parent may feel "now I have someone to love me." Therefore, children have expectations set for them. When the child does not meet these expectations, he or she becomes a "high risk/potential" victim of abuse.

Often abusing parents had abusive parents and are recreating the same pattern of parenting with their own children. The same could be said of neglect. Parents have learned from available environment and parenting, deprivation, chaotic living, or inconsistency in rearing make it difficult to learn homemaking skills, child development, and the adequate knowledge needed to maintain a home and provide adequately for the emotional, social, nutritional, and basic needs of children. A depressed parent may have no motivation for keeping up with basic needs; therefore, intervention may be necessary to helm them "up" to a level of functioning. Quite often a crisis situation produces, in "high risk families" (those having many characteristics prominent to abusing/neglecting parents), a spiraling situation of abuse or neglect. A crisis may be as minor as a child spilling milk or as major as loss of a loved one or financial resources. The emotional, family, community, or professional "support systems" are not there to help a family through stressful times. Again, intervention of a protective service worker or other professionals can led support, guidance, and treatment to help stop or lessen the cycle of dysfunctioning.

Situations of child abuse and neglect occur constantly. The depersonalization and high mobility of modern society may add to the loss of support systems and emotional fulfillment essential to social living. Professionals in this area recognize the right of the children to have their emotional and physical well being met adequately. It has only been in the last two decades that any significant legislation has been passed to help ensure this. In implementing legislation, however, we are behind. Professionals lack training to recognize the problem or to get involved. Social attitudes perpetuate the concept that children are property of the parents and that parents' rights supersede their children. Publicly, there is apathy or indifference. Only recently has the problem of child abuse and neglect became a serious concern.

Characteristics of Child Abuse and Neglect

Any one or more of these may or may not constitute a neglect or abuse situation. A complication of several does indicate protective services needed.

"High Risk" families may be identified where parents are unable to carry out family living roles that are conductive to the emotional, physical, and social well being of children.

1. Inadequate Child Care
    a. Lack of supervision according to child's age and maturity. Example: habitually leaving a preschooler alone, or an older child (10-11) in charge of an infant or preschooler's care or leaving alone at night.
    b. Abandonment. May be temporarily not returning to pick up child from substitute care for a day or several days without contacting childcare provider.
    c. Permanent abandonment. Intentionally leaving a child with or without substitute care.

2. General Neglect - Usually passive; leaving gaps in care of the child resulting in deprivation of minimally accepted standards of food, shelter, clothing, medical attention, education (when appropriate).

a. School attendance. Is the reason for poor school attendance due to the parent or the child? Is the parent not assuming responsibility for sending the child to school (1^{st}-6^{th} grade)?
b. Inadequate clothing. Is clothing inappropriate to the extent that the child's health is endangered? Is the clothing clean or filthy? Usually or occasionally?
c. Unsafe, unsanitary housing. Is the condition of the house dangerous to the welfare of the child? Example: exposure to electrical outlets and wire, open fires, unvented gas stoves, no water supply, accumulated filth.
d. Medical and dental neglect. Are there identified medical problems with resources available for treatment but the parent refuses to take the child for treatment?

3. Emotional Abuse
    a. Chaotic lifestyle that may include violence witnessed, continued indifference to the child, and drug abuse including alcohol. (This may include chronic exposure to prostitution or abnormal sexual practices in the home.)
    b. Character of parents. While parents love and care for the children in the best way they know how, such care is continually inadequate for even minimal growth and development. (The environment may be grossly inconsistent or grossly not within range of social norms.) May or may not be a severe situation to the child.
    c. Verbal abuse. Name calling, singling out for "different" treatment, belittling, constant criticism.
    d. Ignoring child's serious emotional problems.

4. Gross Neglect and Abuse
    a. Malnutrition. Does the child have inadequate nutrition resulting from insufficient food or improper diet?
    b. Failure to thrive (FTT):
        i. Weight below the 3^{rd} percentile with subsequent weight gain in the presence of appropriate nurturing.
        ii. No evidence of systemic disease. Abnormality, or physical examination and laboratory investigation that explained growth failure.
        iii. Development retardation with subsequent acceleration of development following appropriate stimulation and feeding.
        iv. Clinical signs of deprivation that decreases in a more nurturing environment.
        v. Presence of significant environmental psychosocial disruption.
    c. Spanking. Even "light" spanking is inappropriate when the child is too young to understand reason (less than one year inappropriate, 1½ years-if communicating).
    d. Over-discipline. The method of punishment lasts too long or is too frequent or intense. Usually the only method of punishment. Parents were often "parented" in the same way and do not see themselves as using inappropriate methods. (Unless an extension of severe family disfuctioning, rejection of the child or other pathology … children are best treated as a family unit. Removal not usually recommended. All children within the family usually receive some kind of parenting practice.)
    e. Battered child. The child who has sustained serious physical or mental injuries as a result of non-accidental means and for which the parents or guardian are responsible. Often the child who is seen by the parent(s) as being different is singled out. Parent(s) may exhibit impulsive behavior, loss of control, needs are "now" directed, feelings toward child may be superficial. Placement of child usually is indicated.
    f. Sadistic, psychotic parenting. In addition to battering, use of exotic punishment (e.g., biting, hanging, stabbing, cigarette burns, needle marks, forced substance ingestion, deliberated starvation). There is some planning on the part of parent and receiving of satisfaction in inflicting pain. Removal of a child or children is usually immediate.
    g. Sexual abuse as describe previously.

Adult Abuse

There is legislation requiring the reporting of abuse or neglect of certain adults. Adults covered under legislation include "residents" which are all individuals kept, cared for, treated, boarded, or otherwise accommodated in any adult care home. "Adult care home" (as defined by section 29-923) includes any skilled nursing home, intermediate nursing care home, intermediate personal care home, one- or two-bed adult care home, and any boarding care home.

The reporting requirements also extend to adults cared for in an adult family home which is a private residence in which care is provided for not less that 24 hours in any week for one or two adult clients who are not related by blood or marriage within the third degree of relationship to the owner or provider. These residents, by reason of aging, illness, disease, or physical or mental infirmity are unable to live independently but essentially are capable of managing their own care and affairs. Additionally, the reporting requirement applies to any individual kept, cared for, treated, boarded, or otherwise accommodated in a medical facility that is operated by the state or federal government.

The reporting requirements mandatory for any person who is:

1. licensed to practice any branch of the healing arts,
2. a certified psychologist,
3. the chief administrative officer of a medical care facility,
4. an adult care home administrator,
5. a licensed social worker, or
6. a licensed professional nurse or licensed practical nurse.

There must be reasonable cause to believe that a resident is being or has been abused or neglected, or is in a condition which is the result of such abuse or neglect, or is in need of protective services. "Abuse" includes neglect, willful infliction of physical or mental injury, or willful deprivation by a caretaker of services that are necessary to maintain physical and mental health. "Neglect" is defined as the failure of a caretaker to maintain reasonable care and treatment to such an extent that the resident's health or emotional well-being is injured.

The report is to include the following:

1. the name and address of the person making the report;
2. the name and address of the caretaker caring for the resident;
3. the name and address of the involved resident;
4. information regarding the nature and extend of the abuse, neglect, or exploitation;
5. the name of the next of kin of the resident; and
6. any other information, which the person making the report believes, might be helpful in an investigation of the case and the protection of the resident.

Notice of the requirements of this act and identification of the department to which a report is to be made must be posted in a conspicuous place in every adult care home and adult family home in Kansas.

The failure for any person required to report information or cause a report of information to be made, who knowingly fails to make such report or cause such report to be made, will be guilty of a Class B misdemeanor. This is punishable by a maximum fine of $1,000 and a term of imprisonment not to exceed six months.

Anyone participating in the naming of a report in any follow-up activity to or an investigation of such report will not be subject to civil or criminal liability unless the person acted in bad faith or with malicious purpose. This immunity also extends to an individual who testifies in any administrative or judicial proceeding arising from the report. Additionally, no employer may terminate the employment, prevent or

impair the practice or occupation of, or impose any other sanction on any employee solely for the reason that such employee made or caused to be made a report under this act.

The law now requires licensed nurses and other health care providers to report abuse, neglect, and exploitation of adults not in long-term care facilities in Kansas.

Incident reports must be filed within six hours of discovery and must include the name of the reporter, the name of the abused adult, the nature and extent of abuse, names of any known next of kin, and any other helpful information. Failure to file such a report would be criminal immunity. Furthermore, hospitals are specifically required to permit the SRS access to any records needed for investigation.

If you suspect abuse or neglect of an older person, call:

1-800-922-5330 (Domestic/Community)
Department of Social and Rehabilitation Services

1-800-842-0078 (Nursing Homes)
Department of Aging

Legal Issues in Public Health Nursing

1. Legal Obligations

   Public health, community health and home health nurses must be aware of basic legal issues relevant to nursing practice in general, and to public health legal issues specifically. The sources and purposes of public health law must be understood in addition to other statutory, administrative, and common law principles that apply to all nurses. The legal responsibilities of public health nurse vary somewhat from those of nurses working in hospitals.

   Public health nursing practice may impose greater legal obligations because of the autonomy enjoyed by persons who are practicing "in the field," where independent judgments must be made. Professional autonomy and accountability demand special attention to legal and ethical dilemmas faced by persons who must establish a professional nurse-patient relationship in community settings. Additionally, the community-based nurse must be aware of the employing agencies' policies and procedures and the differing expectations, of public versus private agencies. Qualified legal immunities may exist for nurses working in public agencies because of the legal principle of sovereign immunity. The nurse in a public agency is the agent of the people, and when the nurse is sued, public funds may be used to settle the claim. Public policy for qualified immunities exists to preserve the public funds. If the nurse is grossly negligent or intentionally causes harm to the client, the nurse does not qualify for this immunity protection.

   Public health nurses' legal responsibilities evolve as society identifies patient needs and rights that must be protected. Many advocacy groups have developed to educate the public, including health care providers, about the needs of community-based clients. The public media are also an unlikely, yet ongoing source of information related to problems with the public's health.

   Public health nurses must be aware of state and federal statutory laws as well as legal case decisions that pertain to the public's health. Numerous administrative rules and regulations, enacted by state boards of nursing, for example, also relate directly to community health practice.

   Legislation and regulations to protect the public's health are primarily enacted by the state governments. However, some federal guidelines exist and are issued through agencies such as the Centers for Disease Control and Prevention (CDC) and the Occupational Safety and Health Administration (OSHA). Data collection, analysis, surveillance of programs, and issuance of guidelines are mainly the role of the federal Congress or administrative bodies, including the Public

Health Service and the CDC. OSHA requirements relate mainly to providing a safe and healthy working environment for employees.

Public health nurses have the responsibility to become familiar with health codes at both the local and state levels. Orientation to the laws specific to public health nursing should be discussed at the nurse's orientation to employment. If this service is not provided, the nurse must consult with his or her supervisor, local health officer, or the legal counsel for the agency to become familiar with these legal responsibilities. Continuing education programs may be another source for becoming aware of the public health nurse's specific legal obligations. Additionally, common law or case precedence discusses legal issues in the community. These case decisions can also guide the public health nurse's development of an awareness of specific legal obligations.

The nurse working in a public health setting who has questions regarding the legality of procedures that are included in a job description or the scope of nursing within the state would be wise to request that his or her supervisor verify the nurse's role with the attorney general. The attorney general is the official legal counsel for public agencies. If the legal issues are of such concern that the nurse believes his or her liability risks are great, a written formal opinion may be requested from the attorney general's office. It is recommended that the nurse work through the correct channels of communication in the agency to make such a request.

2. Avoiding Malpractice Claims

Nurses can limit their potential liability in several ways. Possibly the first and most important concept to remember is that the patient and the patient's family who are treated honestly, openly, and respectfully and who are apprised of all facets of treatment and prognosis are not likely to sue. Communications done in a caring and professional manner have been shown time and time again to be a major reason why more people do not sue, despite adequate grounds for a successful lawsuit. Even given untoward results and a major setback, the patient is less likely to file suit if there has been an open and trusting nurse-patient relationship or physician-patient relationship. Remember that it is people who sue, not the action or event that triggered a bad outcome.

Second, nurses should know relevant law and legal doctrines, and they should combine these concepts with the biological and psychological, and social sciences that form part of the basis of all rational nursing decisions. The law can and should be incorporated into everyday practice as a safeguard for the health care provider as well as the health care recipient.

Third, nurses should stay well within their areas of individual competence. To remain competent, nurses should upgrade technical skills consistently, continuously attend pertinent continuing education and in-service programs on a regular basis and undertake only those actual skills that they can perform competently.

Fourth, joining and actively supporting professional organizations allows nurses to participate in either excellent educational programs and to become active in the organizations' lobbying efforts, especially if it means a stronger nurse practice act or the creation or expansion of advanced nursing roles. Far too many nurses are reluctant to become politically involved. Yet, as a unified profession, nursing could have a very strong voice, particularly in upgrading and strengthening nurse practice acts.

Fifth, recognize the concept of the *suit-prone patient*. This type of patient is more likely than other patients to initiate malpractice action in the event that something untoward happens during the treatment process. Because the psychological make-up of these persons breeds resentment and dissatisfaction in all phases of their lives, they are more apt to initiate a lawsuit.

Suit-prone patients tend to be immature, overly dependent, hostile, and uncooperative, often failing to follow a designated plan of care. Unable to be self-critical, they shift blame to others as a way of coping with their own inadequacies. Suit-prone patients actually project their fear, insecurity, and anxiety to health care providers, overreacting to any perceived slight in an exaggerated manner.

Recognizing such patients is the first step in avoiding potential lawsuits. The nurse should then attempt to react on a more human, or personal, basis such as expressing satisfaction with these patient's cooperation, showing empathy and concern with unknown treatments and procedures. An atmosphere of attentiveness, caring, and patience helps prevent the suit-prone patient from filing future lawsuits.

Sixth, recognize that nurses' personality traits and behaviors may also trigger lawsuits. So-called *Suit-prone nurses* (1) have difficulty establishing close relationships with others, (2) are insecure and shift blame to others, (3) tend to be insensitive to patients' complaints or fail to take the complaints seriously, (4) have a tendency to be aloof and more concerned with the mechanics of nursing as opposed to establishing meaningful human interactions with patients, and (5) inappropriately delegate responsibilities to peers to avoid personal contact with patients. These nurses need counseling and education to change these behaviors into more positive attitudes and behaviors toward patients and staff. Such positive changes lessen future potential lawsuits.

Seventh, while it may not prevent lawsuits, nurses are urged to investigate having professional liability insurance. This will better protect them should a lawsuit be filed.

3. Professional Liability Insurance

Regardless of the policy chosen, all ***professional liability*** policies share some common elements. The policies provide payment for a lawyer to represent the insured nurse in the event of a claim or lawsuit. Most insurance carriers insist that the nurse use a lawyer whom the insurance company has on retainer because this ensures both the nurse and the insurance carrier that the selected lawyer will be versed in medical malpractice issues. All policies specify the limits of legal liability.

Insurance policies are classified in essentially two ways. The first way is as either occurrence-based or claims-made insurance coverage. ***Occurrence-based policies*** cover the nurse for any injuries arising out of incidents that occurred during the time that the policy was in effect, known as the *policy period*. This holds true even if the subsequent lawsuit is filed after the policy has expired and the policy was not renewed by the policyholder. ***Claims-made policies*** provide coverage only if an injury occurs and the claim is reported to the insurance company during the active policy period or during an uninterrupted extension of that policy period. The uninterrupted extension, or tail, allows the claims-make policy to be enforced for specific periods of time following the policy period.

The occurrence-based policy is preferable for most nurses since lawsuits may not be filed immediately, particularly in cases involving children and infants. Claims-made coverage is adequate if the policy is continuously renewed and kept active or if a tail is purchased of extended coverage. If you have any doubt regarding the coverage needed, consult the insurance agent.

A second way of classifying insurance policies is as individual, group, or employer-sponsored coverage. *Individual coverage* is broadest type of coverage and is specific to the individual policyholder. This type of policy covers *the named policyholder* on a 24-hour basis, as long as actions fall within the scope of professional nursing practice, including both paid services and voluntary services. This type of policy is tailored to meet the needs of the individual nurse. *Group coverage* involves insuring a group of similarly licensed professionals and may be advantageous in some private clinics or businesses. Group coverage is frequently obtained by professional

practitioners where all the insured individuals practice during office hours and have essentially the same job descriptions. ***Employer-sponsored coverage***, which is obtained by institutions, is perhaps the narrowest of coverage for individual nurses since they must first show that they are practicing within the scope of their employment as well as within the scope of professional nursing practice. Those covered are called the *insured*, or they may be referred to as *former insured for acts committed while insured*. Employer-sponsored coverage is favored by the institution since the coverage is written specifically for the business and its major concerns.

The insurance policy should have a section marked ***limits of liability***. This section usually has language about two separate dollar figures. For example, it could read $500,000 each claim, $1,000,000 aggregate, or $1,000,000 each claim, $3,000,000 aggregate. These dollar figures indicate what the insurance company will pay during a given policy period. The company will pay up to the lower limits for any claim or lawsuit and up to the upper limits of the policy during the entire policy period.

4. Summary of Legal Principles and Applications

The role of the public health nurse interfaces with public health laws as well as other legal standards applicable to all nursing roles. Laws are constantly being enacted as revised, and it is therefore impossible to discuss all of the potential laws that a public health nurse must be aware of to enforce and abide by in his or her jurisdiction. Nurses must consistently and constantly update their knowledge of their legal responsibilities. It is difficult to separate and isolate the legal responsibilities of public health nurses because of the natural interrelatedness of the responsibilities to inform patients of their rights to benefits and teach wellness and preventative measures, while recognizing and referring actual and potential problems.

Even laws related to housing and the rights of renters are important to understand. The public health nurse may be faced with the problem of patient-family being evicted from their home or apartment. The impact of this legal action is a legitimate concern for the public health nurse. Laws related to environmental hazards are also being legislated and may be managed under state health departments through sanitation departments, but enforced by nurses. Preventative teaching related to laws requiring the use of seat belts and infant car seats also should be offered. Food preparation and food handler laws are also applicable to public health nursing practice. Nurses can help their patients avoid unsuspected problems by informing them of the legal responsibilities applicable to all people in our society. However, the nurse is not expected, or recommended, to give legal advice to community patients. Ignorance of the law will not protect either the consumer or the nurse from legal liability.

Because the law is constantly changing as our society identifies whose rights need to be protected, the public health nurse must remember the following:

- Keep current regarding the legal standards that govern all nursing practice as well as the regulation and laws specifically enacted to protect the public's health.
- Protect the confidentiality of the information gained by virtue of the therapeutic relationship. Be prepared to disclose information that must legally be reported.
- Share private information regarding patients only with those who need to know, and have the patient's consent in writing for release of information to anyone outside the agency.
- Contracts are evidence of mutually agreed upon terms that should be put in written form to clarify the parties' understanding and serve as evidence of the agreement.
- Public health nurses have professional responsibilities to maintain the standards of care within the scope of nursing practice as defined by their state's nurse practice act.
- Commonly recognized legal duties include the responsibility to maintain a safe working environment and protect the individual safety of patients; teach, inform, and refer patients; communicate in a timely and accurate manner with members of the health care

team; enforce the reporting laws; and be knowledgeable of the laws and programs designed to benefit patients.

- It is unwise for public health nurses to transport patients in their personal vehicles.
- Infectious diseases are considered a disability and therefore persons with HIV/AIDS are legally protected from discriminatory treatment by the Americans with Disabilities Act.
- Dangerous products and equipment must be identified by the nurse to reduce the risk of patient injuries.
- The Occupational Safety and Health Administration and Centers of Disease Control and Prevention are administrative bodies that enact rules and regulations of importance to nurses who work in the community.
- The public health nurse has the responsibility to be familiar with the programs and procedures for assessing these programs, such as Medicare, Medicaid, Early and Periodic Screening, Diagnosis and Treatment Program and Worker's Compensation, for the benefit of their patients.
- Advocacy and professional involvement are appropriate roles for public health nurses who represent vulnerable patients and groups.
- Patients, including psychiatric patients, must be considered to be competent until legally judged by a court of law to be incompetent.
- An expert witness in a legal case involving a public/community health nurse should have experience in the specific area of practice of the defendant as well as comparable educational credentials.
- An employer's expectations of public health nurses must not conflict with the legal scope of nursing practice.
- Standing orders must be reviewed and updated regularly and signed by the physician in a timely manner when acted upon by the nurse.
- Verbal orders are more likely to be misunderstood, and therefore increase the risk of harm to the patient and liability for the nurse. Verbal orders should be avoided and must be followed up with a signature.
- Timely, written documentation of the nurse's actions and the patient's response is necessary evidence of the care provided in the community.
- Supervisory liability may occur when care is delegated to providers who, the supervisor should know, are not prepared to safely perform the task or skills and the patient is harmed.
- Violence is of major concern to nurses who work independently in clinics, homes, schools, and industry, as these environments are impacted by crime that exists in our society.

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APPENDIX

A – Glossary of Helpful Acronyms

AACN	Association of American Colleges of Nursing
AAN	American Academy of Nursing
AAOHN	American Association of Occupational Health Nurses
ABOHN	American Board for Occupation of Health Nurses
ACHNE	Association of Community Health Nurse Educators
AHCPR	Agency for Health Care Policy & Research
ANA	American Nurses Association
ANCC	American Nurses Credentialing Center
APHA	American Public Health Association
APN	Advanced Practice Nurses
ASTDN	Association of State and Territorial Directors of Nursing
ASTHO	Association of State and Territorial Health Officials
ASTLHLO	Association of State and Territorial Local Health Liaison Officials
ATSDR	Agency for Toxic Substances and Disease Registry
BLS	Bureau of Labor Statistics
CAI	Computer-Assisted Instruction
CD-ROM	Computer Disk Read-Only Memory
CDC	Centers for Disease Control and Prevention
CFCs	Chlorofluorocarbons
DHHS	Department of Health and Humans Services
DoD	Department of Defense
EPA	Environmental Protection Agency
FQHC	Federally Qualified Health Center
HCFA	Health Care Financing Administration
HRSA	Health Resources and Services Administration

ICN	International Council of Nursing
IOM	Institute of Medicine
IRB	Institutional Review Board
LPN	Licensed Practical Nurse
MFS	Medical Fee Schedule
NACCHO	National Association of County and City Health Officials
NACNEP	National Advisory Council for Nurse Education and Practice
NALBOH	National Association of Local Boards of Health
NANDA	North American Nursing Diagnosis Association
NAPHIC	National Public Health Information Coalition
NAPHSIS	National Association for Public Health Statistics and Information Systems
NBCSN	National Boards for Certification of School Nurses
NCEH	National Center for Environmental Health
NCLEX	National Council Licensure Examination for Registered Nurses
NCSBN	National Council of State Boards of Nursing
NIEHS	National Institute of Environmental Health Services
NIH	National Institute of Health
NIJ	National Institute of Justice
NINR	National Institute of Nursing Research
NIOSH	National Institute for Occupational Safety and Health
NLN	National League for Nursing
NP	Nurse Practitioner
OSHA	Occupational Safety and Health Administration
PHF	Public Health Foundation
PPRC	Physician Payment Review Commission
RN	Registered Nurse

STTI	Sigma Theta Tau International
TRI	Toxic Chemical Release Inventory
USPHS	United States Public Health Services

B – Managed Care – Glossary of Terms
(Prepared for Kansas Health Foundation Leadership institute 1995)

Alliance: An organization of consumers that is responsible for purchasing health insurance as a large group.

Basic Health Services: Benefits that all federally qualified HMOs must offer; defined under Subpart A, 110.102 of the Federal HMO Regulations.

Benefit Package: A collection of specific services or benefits that the HMO is obligated to provide under terms of its contracts with subscriber groups or individuals.

Capitation payment: A method of payment for health services. The health care provider is paid a fixed (per capita) amount for each person receiving care regardless of the number or nature of services provided. It is the usual form of payment for Health Maintenance Organizations and Preferred Provider Organizations (HMOs and PPOs). Its goal is to reduce health care costs by encouraging more conservative health care delivery.

Coinsurance: The portion of the cost for care received and for which an individual is financially responsible. Usually this is determined by a fixed percentage, as in major medical coverage. Often coinsurance applies after a specified deductible has been met.

Community Rating: a method for determining health insurance premiums based on actual or anticipated costs in a specific geographic location as opposed to an experience rating that looks at individual characteristics of the insured.

Co-payment: A payment made by an HMO enrollee at the time that selected services are rendered. Some employer benefit packages require a co-payment between $2.00 and $20.00 for each doctor's office visit. Some impose a fixed dollar amount for inpatient hospitalization. Co-payments are subject to limitation as defined in subpart 1, 110-101 of the Federal HMO Regulations.

Deductible: The part of an individual's health care expenses that the patient must pay before coverage from the insurer begins**.**

Diagnostic related groups (DRGs): Classification used by the federal government to establish prospective prices paid to hospitals for patients covered by Medicare. Each of the 467 groups is based upon a diagnosis or illness category.

Fee-for-Service (FFS): The patient is charged according to a fee schedule set for each service and/or procedure to be provided and the patient's total bill will vary by the number of services/procedures actually received. The patient is billed at the time of service.

Gatekeeper: A primary care physician is an HMO who makes referrals. His/her function is to reduce health care utilization and costs.

Group Model HMO: There are two kinds of group model HMOs. The first type of group model is called the closed panel, in which medical services are delivered in the HMO owned health center or satellite clinic by physicians who belong to a formed but legally separate HMO. The group is paid a negotiated monthly capitation fee by the HMO, and the physicians in turn are salaried and generally prohibited from carrying on any fee-for-service practice. In the second type of group model, the HMO contracts with an existing, independent group of physicians to deliver medical care. Usually, an existing multi-specialty group practice adds a prepaid component to its fee-for-service mode and affiliates with or forms an HMO. Medical

services are delivered at the group's clinic facilities (both to fee-for-service patients and to prepaid HMO members). The group may contract with more than one HMO.

Health Maintenance Organization (HMO): An organization of health care personnel and facilities that provides a comprehensive range of health services to an enrolled population for a fixed sum of money paid in advance for a specified period of time. These health services include a wide variety of medical treatments and consults, inpatient and outpatient hospitalization, home health service, ambulance service, and sometimes dental and pharmacy services. The HMO may be organized as a group model, an individual practice association (IPA), a network model or a staff model.

Hold Harmless: Managed care contracts often include a clause stating if either the HMO or physician is held liable for malpractice or corporate malfeasance, the other party is not.

Individual Practice Association (IPA): Under this structure physicians practicing in their own offices, participate in a prepaid healthcare plan. The physicians charge agreed-upon rates to enrolled patients and bill the IPA on a fee-for-service basis.

Long-term care: Persons who are chronically ill, elderly, or physically and/or mentally disabled may require health care on a long-term basis either in their home or in an institution. For some people, the costs of long-term care may be covered by private insurance or Medicare, but generally there are upper limits after which all costs must be paid by the patient.

Managed Care: Use of a planned and coordinated approach to providing healthcare with the goal of quality care at a lower cost. Usually emphasizes preventive care and often associated with an HMO.

Managed Competition: A system proposed in 1993 by the Jackson Hole Group that suggests the individual employee receive a fixed sum from his/her employer and the individual employee chooses the health plan they prefer. If the plan they choose costs more than the employer's fixed sum, the employee is responsible for the difference. The individual employee would have a tax incentive to select the lower priced options because they would only be able to deduct the amount of the lowest cost option. The proposal's proponents believe this would encourage individual consumers of healthcare to be more price conscious and they also believe this will cause healthcare insurers to hold down the cost of their plans to make them more competitive. Because insurance under this proposed system is not tied to the employer, employees would not lose coverage when they change jobs. Under this proposed system there is no provision to set premiums that appropriately cover the risk of an individual patient or specific patient population.

Market Share: That part of the market potential that an HMO or a fee-for-service/prepaid medical group has captured; usually market share is expressed as a percentage of the market potential.

Medicaid: A state-administered program financed by federal and state funds offering medical aid to the financially needy of all ages. Covers all persons who receive federal welfare assistance. Provides for inpatient hospital care, outpatient care, doctors' services, nursing home care, lab and X-ray services, and some home health care. A wide variety of optional services may be available in individual states.

Medicare: A federal health insurance program available to everyone age 65 or older, persons under age 65 who have been disabled for two years and most people requiring kidney dialysis. Consists of two parts—Part A, which covers hospital and limited nursing home stays, and Part B which covers physician services.

Nurse practitioner: There are different types of nurse practitioners. All are registered nurses who receive additional training and work under their own professional license. Nurse practitioners do health

exams, treat minor and chronic illnesses, and provide patient education and counseling. In most states, nurse practitioners can prescribe certain types of medications.

Physician Assistants: Physician Assistants receive two years of special training in human biology, diagnosis, and treatment. They generally work under a supervising physician who is responsible for the medical care they provide. Physician assistants provide direct medical care, such as giving shots and treating minor illnesses, as well as patient education.

Pre-existing condition: A health ailment that the insured person had before purchasing insurance. Generally, pre-existing conditions are not covered by insurance policies.

Preferred Provider Organization (PPO): A group of physicians and/or hospitals that contract with an employer to provide services to their employees. In a PPO the patient may go to the physician of his/her choice, even if that physician does not participate in the PPO, but the patient receives care at a lower benefit level.

Preventive Health Services: Services aimed at preventing a disease from occurring, or preventing or minimizing its consequences. This includes care aimed at warding off illnesses (e.g., immunizations), at early detection of disease (e.g., pap smears) or at stopping further deterioration (e.g., exercise).

Primary Care Network: The structure for these networks will vary considerably depending on the specific network. It may range from a loose association of physicians in a geographic area with a limited sharing of overhead, patient referral, etc. to a more structured association with community owned satellite clinics, etc.

Primary Care Physician (PCP): Provides treatment of routine injuries and illnesses and focuses on preventive care. Serves as gatekeeper for managed care. The American Academy of Family Practice defines primary care as "care from doctors trained to handle health concerns not limited by problem origin, organ systems, gender or diagnosis."

Prospective Pricing: A method by which the amount paid to hospitals for services rendered to Medicare patients is determined in advance, based on the diagnostic related group into which the patient is categorized. It was enacted as part of the Social Security Amendments of 1983.

Providers: Those institutions and individuals who are licensed to provide health care services (for example, hospitals, skilled nursing facilities, physicians, pharmacists, etc.) Providers in a defined service area are principally owned by, affiliated with, employed by, or under contract to an HMO.

Quality Assurance Program: An internal peer review process that audits the quality of care delivered. The program should include an educational mechanism to identify and prevent discrepancies in care.

Rationing: Limiting the amount of health care provided a patient, based on the availability of services or the patent's ability to pay for services.

Risk: The chance or possibility of loss. For example, physicians may be held at risk if hospitalization rates exceed agreed-upon thresholds. The sharing of risk is often employed as a utilization control mechanism within the HMO setting. Risk is also defined in insurance terms as the probability of loss associated with a given population.

Risk Pool: Funds are set aside to cover over-utilization or to encourage limits on utilization. More commonly seen in primary care that with specialists.

Single payer system: A health reform plan that would designate one entity, usually the government, to function as the only purchaser of health care services.

Total Quality Management (TQM): Also called continuous quality improvement and uses the concepts originally developed by W. Edward Deming to study systems and processes at medical groups to identify and improve sources of error, waste or redundancy. Uses input and feedback from all staff and patients to understand and improve on problems in current procedures.

Underinsured: Health insurance policies vary in the degree to which hospital and other medical costs are covered. Some plans cover only hospitalization and critical medical care and require co-payments and have large deductibles. Persons are underinsured if they must pay most of their health care costs.

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C – Selected Resources

Organizations

National Organizations

Association of State and Territorial Directors of Nursing
c/o Association of State and Territorial Health Officers (which see)

Association of State and Territorial Health Officials
1275 K Street NW, Suite 800
Washington, D.C. 20005-4006
202-371-9090
http://www.astho.org

American Nurses Association
600 Maryland Avenue SW
Washington, D.C. 20024
800-274-4262
http://www.nursingworld.org

American Public Health Association
800 I Street NW
Washington, D.C. 20001
202-777-2742
http://www.apha.org

Centers for Disease Control and Prevention
1600 Clifton Road NW
Atlanta, GA 30333
404-639-3311
http://www.cdc.gov

CDC Public Health Training Network (PHTN)
1600 Clifton Road NW
Atlanta, GA 30333
800-311-3435
http://www.phppo.cdc.gov/phtn/default.asp

National Association of City and County Health Officials
1100 17th Street NW, Second Floor
Washington, D.C. 20036
202-783-5550
202-783-1583 (fax)
http://www.naccho.org/index.cfm

National Association of Local Boards of Health
1840 East Gypsy Lane Road
Bowling Green, OH 43402
419-353-7714
4190352-6278 (fax)
nalboh@nalboh.org
http://www.nalboh.org

National Council of State Boards of Nursing, Inc.
111 East Wacker Drive, Suite 2900
Chicago, IL 60601
312-525-3600
312-279-1032 (fax)
866-293-9600 (testing)
http://www.ncsbn.org

Public Health Foundation
1220 L Street NW, Suite 350
Washington, D.C. 20005
202-898-5600
202-898-5609 (fax)
info@phf.org
http://www.phf.org

Public Health Service
Office of the Chief Nurse
U.S. Department of Health and Human Services
Parklawn Building, Room 11-05
5600 Fishers Lane
Rockville, MD 20857
301-443-6853
301-443-1164 (fax)

Regional Organizations

Department of Health and Human Services
Region VII Office (for FLSA Medical Leave Act of 1993)
601 East 12th Street, Room 501
Kansas City, MO 64106
816-426-2821
http://www.hhs.gov/region7

OSHA, Region VII
City Center Square
1100 Main Street, Suite 800
Kansas City, MO 64105
816-426-5861
816-426-2750 (fax)

OSHA Region VII
271 W. 3rd Street N., Room 400
Wichita, KS 67202
316-269-6644
316-296-6185 (fax)
800-362-2896 (toll free for Kansas residents only)

U.S. Environmental Protection Agency (USEPA) Region VII
Office of External Programs
901 N. 5th Street
Kansas City, KS 66101
913-551-7003

913-551-7066 (fax)
800-223-0425
http://www.epa.gov/region7

State Organizations

Child Health Assessment Nurse Provider Program (CHANP)
Division of Continuing Education
Washburn University
1700 College Avenue
Topeka, KS 66621
785-231-1010 ext 1399
ce@washburn.edu
http://www.washburn.edu/ce/HealthandNursing.html

Kansas Action for Children, Inc. (for: "Kids Count" data book)
3660 SW Harrison
Topeka, KS 66611
785-232-0550
785-232-0699 (fax)
kac@kac.org
http://www.kac.org

Kansas Association for the Medically Underserved
112 SW 6th, Suite 201
Topeka, KS 66603
785-233-8483

Kansas Association of Local Health Departments
PO Box 780406
Wichita, KS 67278-0406
316-296-1722

Kansas Department of Human Resources
Commission on Disability Concerns (ADA)
1430 SW Topeka
Topeka, KS 66612
785-296-1722
800-295-5232 (outside Topeka)
http://adabbs.hr.state.ks.us/dc/index.html

Kansas Department of Social and Rehabilitation Services
Docking State Office Building
915 SW Harrison
Topeka, KS 66612-1570
785-296-3959
785-296-2173 (fax)
http://www.srskansas.org

Kansas Department of Health and Environment
Office of Local and Rural Health
Curtis Building
1000 SW Jackson, Suite 340

Topeka, KS 66612-1365
785-296-1200
785-296-1231 (fax)
http://www.kdhe.state.ks.us/olrh/index.html

Kansas Health Foundation
309 East Douglas
Wichita, KS 67202-3405
316-262-7676
316-262-2044 (fax)
800-373-7681 (outside Wichita)
info@khf.org
http://www.kansashealth.org

Kansas Hospital Association
215 SE 8th Street
PO Box 2308
Topeka, KS 66601-2308
785-233-7436
785-233-6955
http://www.kha-net.org

Kansas Public Health Association
215 SE 8th Ave.
Topeka, KS 66603-3906
785-233-3103
785-233-3439 (fax)
kpha@networksplus.net
http://www.kpha.myassociation.com/shared/layouts/newsprint.jsp?_event=view&_id=120130_c_sU128181_s_i137986

Kansas State Board of Nursing (source for Nurse Practice Act)
Landon State Office Building
900 SW Jackson, Suite 1051
Topeka, KS 66612-1230
785-296-4929
785-296-3929
http://www.ksbn.org

Kansas State Historical Society
6425 SW 6th Avenue
Topeka, KS 66615-1099
785-272-8681
785-272-8682 (fax)
http://www.kshs.org

Kansas State Nurses Association
1208 SW Tyler
Topeka, KS 66612-1735
785-233-8638
785-233-5222 (fax)
troberts@sound.net
http://www.nursingworld.org/snas/ks

Kansas State University, Community Health
101 Umberger Hall
Manhattan, KS 66506-3403
785-532-7750
785-532-7733
healthyplaces@ksu.edu
http://healthyplaces.ksu.edu/HealthyPlaces

Poison Control Center
University of Kansas Medical Center
Department of Pharmacy
3901 Rainbow Blvd.
Kansas City, KS 66160-7231
913-588-6633
913-588-2350 (fax)
http://www2.kumc.edu/pharmacy/poison

Community Tool Box
University of Kansas
4082 Dole Human Development Center
1000 Sunnyside Avenue
Lawrence, KS 66045-7555
785-864-0533
785-864-5281 (fax)
ToolBox@ukans.edu
http://ctb.ku.edu

Web Addresses for Information KDHE

Service guide to the Division of Environment maybe found at:
http://www.kdhe.state.ks.us/environment/servguid

Service guide to the Division of Health maybe found at: http://www.kdhe.state.ks.us/health/servguid

Kansas Public Health and Environment Information Library Catalogue maybe found at:
http://www.kdhe.state.ks.us/library/index

Kansas Annual Summary of Vital Statistics maybe found at: http://www.kdhe.state.ks.us/ches

Division of Health:
Bureau for Children, Youth, and Families: http://www.kdhe.state.ks.us/bcyf

Bureau of Consumer Health: http://www.kdhe.state.ks.us/bch

` Bureau of Epidemiologic and Disease Prevention: http://www.kdhe.state.ks.us/bedp

Bureau of Health Promotion: http://www.kdhe.state.ks.us/bhp

Office of Local and Rural Health: http://www.kdhe.state.ks.us/olrh

KDHE Home Page: http://www.kdhe.state.ks.us

KDHE Literature: http://www.kdhe.state.ks.us/health-info

D – Public Health Competencies

Public Health in America

VISION:
Healthy People in Healthy Communities

MISSION:
Promote Health and Prevent Disease and Injury

Public Health:

- Prevents epidemics and the spread of disease
- Protects against environmental hazards
- Prevents injuries
- Promotes and encourages healthy behaviors
- Responds to disasters and assists communities in recovery
- Assures the quality and accessibility of health services

Essential Public Health Services:

- Monitor health status to identify and solve community health problems
- Diagnose and investigate health problems and health hazards in the community
- Inform, educate, and empower people about health issues
- Mobilize community partnerships and action to identify and solve health problems
- Develop policies and plans that support individual and community health efforts
- Enforce laws and regulations that protect health and ensure safety
- Link people to needed personal health services and assure the provision of health care when otherwise unavailable
- Assure a competent public health and personal health care workforce
- Evaluate effectiveness, accessibility, and quality of personal and population-based health services
- Research for new insights and innovative solutions to health problems

Essential Service #1: Monitor health status to identify community health problems.

Competencies:

Analytic Skills

- Define a problem
- Determine appropriate use of data and statistical methods for problem identification and resolution, and program planning, implementation and evaluation.
- Select and define variables relevant to defined public health problems.
- Evaluate the integrity and comparability of data and identifying gaps in data sources.

- Understand how the data illuminate ethical, political, scientific, economic, and overall public health issues
- Understand basic research designs used in public health
- Make relevant inferences from data

Communication Skills

- Communicate effectively both in writing and orally (unless a handicap preludes one of these forms of communication)
- Present accurately and effectively demographic, statistical, programmatic, and scientific information for professional and lay audiences
- Solicit input from individuals and organizations
- Advocate for public health programs and resources
- Lead and participate in groups to address specific issues
- Use the media to communicate public health information

Public and Development/Program Planning Skills

- Collect and summarize data relevant to an issue

Basic Public Health Sciences Skills

- Define, assess, and understand the health status of populations, determinants of health and illness, factors contributing to health promotion and disease prevention, and factors influencing the use of health services
- Apply the basic public health sciences including behavioral and social sciences bio-statistics, epidemiology, environmental public health, and prevention of chronic and infectious diseases and injuries

New

- Understand risk assessment and risk communication skills
- Understand how to use public health software packages such as Epi-Info to track, analyze and present findings of community health problems
- Design and operate a surveillance system
- Understand analytic skills for survey development and administration
- Understand the role and importance of vital statistics
- Understand computer/information technology applications (specifics?)
- Knowledge of existing sources of data
- Describe problems in terms of time (persistence), magnitude/severity (scope), dispersion/location (place), and co-occurrence/co-morbidity
- Demonstrate ethical (including sensitive, confidential) conduct in practice, research, data collection and storage, and program management
- Effectively function in culturally diverse settings, assess cross-cultural relations, adapt professional behavior to unique needs, assess and promote cultural competence of employee/organization

Essential Service #2: Diagnose and investigate health problems and health hazards in the community.

Competencies:

Analytical Skills

- Define a problem
- Determine appropriate use of data and statistical methods for problem identification and resolution, and program planning, implementation and evaluation
- Select and define variable relevant to defined public health problems
- Evaluate the integrity and comparability of data and identifying gaps in data sources

- Understand how the data illuminate ethical, political, scientific, economic, and overall public health issues
- Understand basic research designs used in public health
- Make relevant inferences from data

Communication Skills

- Communicate effectively both in writing and orally (unless a handicap precludes one of these forms of communication)
- Present accurately and effectively demographic, statistical, programmatic, and scientific information for professional and lay audiences
- Solicit input from individuals and organizations
- Lead and participate in groups to address specific issues
- Use the media to communicate public health information

Policy and Development/Program Planning Skills

- Collect and summarize data relevant to an issue
- State policy options
- Articulate the health, fiscal, administrative, legal, social, and political implications of each policy option
- State the feasibility and expected outcomes of each policy option

Cultural Skills

- Understand the dynamic forces contributing to cultural diversity
- Interact sensitively, effectively, and professionally with persons from diverse cultural, socioeconomic, educational, and professional backgrounds, and with persons of all ages and lifestyle preferences
- Identify the role of cultural, social, and behavioral factors in determining disease, disease prevention, health promoting behavior, and medical service organization and delivery
- Develop and adapting approached to problems that take into account cultural differences

Basic Public Health Sciences Skills

- Define, assess, and understand the health status of populations, determinants of health and illness, factors contributing to health promotion and disease prevention, and factors influencing the use of health services
- Understand research methods in all basic public health sciences
- Apply the basic public health sciences including behavioral and social sciences, biostatistics, epidemiology, environmental public health, and prevention of chronic and infectious diseases and injuries

New:

- Understand environmental health issues and environmental morbidity factors
- Establish ties with non-traditional public health providers such as school health clinics and occupational safety office in industry
- Utilize risk assessments (i.e. identifying hazardous exposure and health effects)
- Apply laboratory science skills
- Understand study design, including outbreak/cluster investigation
- Facilitate interview (including cultural competence) and qualitative survey methods
- Utilize public relation skills
- Knowledge of existing network of consultants and technical assistance, community-based assets to collect, analyze community health data
- Understand relevant legal and regulatory information
- Identify the scientific underpinnings, and ascertain strength of evidence from literature, including effectiveness of interventions

- Prepare and interpret data from vital statistics, census, surveys, service utilization, and other relevant special reports

Essential Service #3: Inform, educate, and empower people about health issues.

Competencies:

Communication Skills

- Communicate effectively both in writing and orally (unless a handicap precludes one of these forms of communication)
- Present accurately and effectively demographic, statistical, programmatic, and scientific information for professional and lay audiences (i.e. risk communication)
- Solicit input from individuals and organizations
- Advocate for public health programs and resources
- Lead and participate in groups to address specific issues
- Use the medial and advanced technologies to communicate public health information

Cultural Skills

- Understand the dynamic forces contributing to cultural diversity
- Interact sensitively, effectively, and professionally with persons from diverse cultural, socioeconomic, educational, and professional backgrounds, and with persons of all ages and lifestyle preference.
- Identify the role of cultural, social, and behavioral factors in determining disease, disease prevention, health promoting behavior, and medical service organization and delivery
- Develop and adapt approaches to problems that take into account cultural differences

New

- Understand psychosocial and behavioral theories (e.g., health belief model)
- Establish measurable goals and objectives
- Understand how public and private agencies within a community operate
- Understand risk assessment and health risk assessment methodologies
- Translate education information into compelling sound "bytes"
- Knowledge of how to use the legal and political system to effect change
- Understand different theories on education and of learning

Essential service #4: Mobilize community partnerships to identify and solve health problems
Note: to identify and solve problems – those competencies are reflected for essential services #1, 2, and 5. Therefore the competencies listed here reflect those needed to mobilize community partnerships.

Competencies:

Communication Skills

- Communicate effectively and persuasively both in writing and orally (unless a handicap precludes on of these forms of communication)
- Present accurately and effectively demographic, statistical, programmatic, and scientific information for professional and lay audiences
- Solicit input form individuals and organizations
- Advocate for public health programs and resources
- Lead and participate in groups to address specific issues
- Use the media to communicate public health information

Cultural Skills

- Understand the dynamic forces contributing to cultural diversity

- Interact sensitively, effectively, and professionally with persons from diverse cultural, socioeconomic, educational and professional backgrounds, and with persons of all ages and lifestyle preferences
- Identify the role of cultural, social, and behavioral factors in determining disease, disease prevention, health promoting behavior, and medical service organization and delivery
- Develop and adapt approaches to problems that take into account cultural difference

New

- Establish ties with non-traditional public health providers (such as businesses, managed care organizations and other healthcare providers, schools, other government agencies, volunteer and non-profit organizations, advocacy groups, community groups, hospitals, physicians, insurers, faith and church groups)
- Understand the existing network of consultants and technical assistance, community-based assets to collect and analyze community health data
- Utilize leadership team building, negotiation and conflict resolution skills to build community partnerships
- Foster community empowerment, involvement and power sharing whenever possible in the design. Implementation and research aspects of programs and systems

Essential Service #5: Develop policies and plans that support individual and community health efforts.

Competencies:

Communication Skills

- Use the media and advanced technologies to communicate public health information

Policy and Development/Program Planning Skills

- Collect and summarize data relevant to an issue and test its reliability
- State policy options
- Articulate the health, fiscal, administrative, legal, social, and political implications of each policy option
- State the feasibility and expected outcomes of each policy option
- Utilize current techniques in decision analysis
- Write a clear and concise policy statement
- Develop a plan to implement the policy, including goals, outcome and process objectives, and implementation steps
- Translate policy into organizational plans, structures, and programs
- Identify public health laws, regulations, and policies related to specific programs
- Develop mechanisms to monitor and evaluate programs for their effectiveness and quality

Cultural Skills

- Understand the dynamic forces contributing to cultural diversity
- Interact sensitively, effectively, and professionally with persons form diverse cultural, socioeconomic, educational, and professional backgrounds, and with persons of all ages and lifestyle preferences
- Identify the role of cultural, social, and behavioral factors in determining disease, disease prevention, health promoting behavior, and medical service organization and delivery
- Develop and adapt approaches to problems that take into account cultural differences

Financial Planning and Management Skills

- Develop and present a budget
- Manage programs within budgetary constraints

- Develop strategies for determining budget priorities
- Monitor program performance
- Prepare proposals for funding from external sources
- Apply basic human relations skills to the management of organizations and the resolution of conflicts
- Manage personnel
- Understand the theory of organizational structure and its relation to professional practice

New:
- Utilize and integrate strategic planning processes, including assessment methodology and modeling when developing policies or community-health plans
- Conduct cost-effectiveness, cost-benefit and cost utility analyses

Essential Service #6: Enforce laws and regulations that protect health and ensure safety.

Competencies:

Communication Skills
- Communicate effectively both in writing and orally (unless a handicap precludes one of these forms of communication)
- Present accurately and effectively demographic, statistical, programmatic, and scientific information for professional and lay audiences (i.e. risk communication)
- Use the media and advanced technologies to communicate public health information

Policy and Development/Program Planning Skills
- Collect and summarize data relevant to an issue including adequate interpretation of historical experiences, activities, and outcomes
- Identify, interpret, and implement public health laws, regulations, and policies related to specific programs

Cultural Skills
- Interact sensitively, effectively, and professionally with persons from diverse cultural, socioeconomic, educational, and professional backgrounds, and with persons of all ages and lifestyle preferences

New
- Utilize creative methods for achieving enforcement and regulation of laws that protect health
- Collaborate with other public agencies and organization (ex. Law Enforcement)
- Manage and monitor the enforcement process (including enforcement personnel, compliance, and development of inspection indicatory)
- Understand risk assessment and health risk assessment methodologies

Essential Service #7: Link people to needed personal health services and assure the provision of health care when otherwise unavailable.

Competencies:

Analytic Skills
- Define a problem
- Make relevant inferences from data

Policy and Development/Program Planning Skills
- Collect and summarize data relevant to an issue

- State policy options
- Articulate the health, fiscal, administrative, legal, social, and political implications of each policy option
- State the feasibility and expected outcomes of each policy option
- Decide on the appropriate course of action
- Write a clear and concise policy statement
- Develop a plan to implement the policy, including goals, outcome and process objectives, and implementation steps
- Translate policy into organizational plans, structures, and programs
- Develop mechanisms to monitor and evaluate programs for their effectiveness and quality

Cultural Skills

- Understand the dynamic forces contributing to cultural diversity
- Interact sensitively, effectively, and professionally with persons from diverse cultural socioeconomic, educational, and professional background, and with persons of all ages and lifestyle preferences
- Identify the role of cultural, social, and behavioral factors in determining disease, disease prevention, health promoting behavior, and medical service organization and delivery
- Develop and adapt approaches to problems that take into account cultural differences

Basic Public Health Sciences Skills

- Define, assess, and understand the health status of populations, determinants of health and illness, factors contributing to health promotion and disease prevention, and factors influencing the use of health services

Financial Planning and Management Skills

- Develop and present a budget
- Manage program within budgetary constraints
- Develop strategies for determining budget priorities
- Monitor program performance
- Prepare proposals for funding from external sources
- Apply basic human relations skills to the management of organizations and the resolution of conflicts
- Manage personnel
- Understand the theory of organizational structure and its relation to professional practice

New

- Negotiate contracts for personal health service
- Identify health needs of special and vulnerable populations
- Utilize case management skills to coordinate care
- Coordinate public health and medicine for optimal care
- Provide or assure provision of comprehensive personal health services including primary and specialty medical and dental care and clinical prevention services
- Prepare and implement emergency response plans

Essential Service #8: Assure a competent public health and personal health care workforce

Competencies:

Analytic Skills

- Determine appropriate use of data and statistical methods for problem identification and resolution and program planning, implementation and evaluation

Policy and Development/Program Planning Skills (policy=privileging, licensing, quality assurance, Credentialing, accreditation of health professionals and of health professions education)

- Collect and summarize data relevant to an issue
- State policy options
- Articulate the health, fiscal, administrative, legal, social, and political implications of each polity option
- State the feasibility and expected outcomes of each policy option
- Decide on the appropriate course of action
- Write a clear and concise policy statement
- Develop a plan to implement the policy, including goals outcomes and process objectives, and implementation steps
- Translate policy into organizational plans, structures, and programs

Cultural Skills

- Interact sensitively, effectively, and professionally with persons from diverse cultural, socioeconomic, educational, and professional backgrounds, and with persons of all ages and lifestyle preferences
- Develop and adapt approaches to problems that take into account cultural differences

Basic Public Health Sciences Skills

- Understand the historical development and structure of state, local, and federal public health agencies

Financial Planning and Management Skills

- Understand the theory of organizational structure and its relation to professional practice

New

- Persuasively express to organizational leaders the value and need for training and education
- Knowledge and use of contemporary learning technologies
- Understand different theories on education and learning

Essential Service #9: Evaluate effectiveness, accessibility, and quality of personal and population based health services.

Competencies:

Analytic Skills

- Evaluate the integrity and comparability of data and identifying gaps on data sources
- Understand how the data illuminate ethical, political scientific, economic, and overall public health issues
- Understand basic research methodologies used in public health and health services research
- Make relevant inferences from data

Communication Skills

- Communicate effectively both in writing and orally (unless a handicap precludes one of these forms of communication)
- Present accurately and effectively demographic, statistical, programmatic, and scientific information for professional and lay audiences
- Solicit input from individuals and organizations
- Advocate for public health programs and resources

Policy and Development/Program Planning Skills

- Collect and summarize data relevant to an issue

- Identify public health laws, regulations and policies related to specific programs
- Develop mechanisms to monitor and evaluate programs for their effectiveness and quality
- Understand analytic skills for survey development and administration

Cultural Skills
- Understand the dynamic forces contributing to cultural diversity
- Interact sensitively, effectively, and professionally with persons from diverse cultural, socioeconomic, educational, and professional backgrounds, and with persons of all ages and lifestyle preferences
- Identify the role of cultural, social, and behavioral factors in determining disease, disease prevention, health promoting behavior, and medical service organization and delivery
- Develop and adapt approach to problems that take into account cultural differences

Basic Public Health Sciences Skills
- Define, assess, and understand the health status of populations determinants of health and illness, factors contributing to health promotion and disease prevention, and factors influencing the use of health services
- Understand research methods in all basic public health sciences
- Apply the basic public health sciences including behavioral and social sciences, biostatistics, epidemiology, environmental public health, and prevention of chronic and infectious diseases and injuries
- Understand the historical development and structure of state, local, and federal public health agencies

Financial Planning and Management Skills
- Monitor program performance
- Understand analytic skills for survey development and administration
- Monitor quality of personal health services provided
- Conduct cost-effectiveness, cost-benefit and cost-utility analyses

Essential Service #10: Research for new insights and innovative solutions to health problems

Competencies:

Analytic Skills
- Define a problem
- Determine appropriate use of data and statistical methods for problem identification and resolution, and program planning, implementation and evaluation
- Select and define variables relevant to defined public health problems
- Evaluate the integrity and comparability of data and identifying gaps in data sources
- Understand how the data illuminate ethical, political, scientific, economic, and overall public health issues
- Understand basic research designs used in public health
- Make relevant inferences from data

Communication Skills
- Use the media to communicate and disseminate results of research findings

Cultural Skills
- Understand the dynamic forces contributing to cultural diversity
- Interact sensitively, effectively, and professionally with persons from diverse cultural, socioeconomic, educational, and professional backgrounds, and with persons of all ages and lifestyle preference

- Identify the role of cultural, social, and behavioral factors in determining disease, disease prevention, health promoting behavior, and medical service organization and delivery
- Develop and adapt approaches to problems that take into account cultural differences

Basic Public Health Sciences Skills

- Define, assess, and understand the health status of populations, determinants of health and illness, factors contributing to health promotion and disease prevention, and factors influencing the use of health services
- Understand research methods in all basic public health sciences
- Apply the basic public health sciences including behavioral and social sciences, biostatistics, epidemiology, environmental public health, and prevention of chronic and infectious diseases and injuries
- Understand the historical development and structure of state, local, and federal public health agencies

New

- Identify specific research methodologies relevant to each of the previous nine essential services
- Conduct collaborative research across multiple disciplines
- Understand budget processes in order to lobby for resources to investigate innovative approaches to health problems

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